Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF MARCH 17, 1958

When Does a Tax Error Become Fraud?

Office Hours? I've Had Enough!

It's Dangerous to Own Things Jointly

What Labor Really Wants From You

Grievance Committee With Teeth

Medical Economics

NEWS BRIEFS

BIGGEST MEDICAL BILLS are currently found in Los Angeles, San Francisco, Cleveland, and Boston, according to one major medical insurance underwriter. Lincoln National Life calls these "the highest cost areas in the country."

NEED A NEW CAR? Dealers are ripe for bargaining. This month their inventories are soaring toward a record total of 900,000 unsold cars.

CRISIS IN 1962: That's when the annual production of new doctors will probably level off. Thereafter, warns the Association of American Medical Colleges, the population will keep growing, but the doctor supply won't—without drastic action now. Details in next issue.

DOCTORS' DONATIONS to medical schools have slipped below the million-dollar-a-year mark established in 1956, the American Medical Education Foundation reports.

NEWS BRIEFS

DO YOU REGULARLY TAKE PATIENTS to two or more hospitals? According to a new study by this magazine, 62% of urologists do—but only 42% of G.P.s. Those are the high and low percentages in the major fields of practice.

MISTAKES ON YOUR TAX RETURN? The U.S. used to forgive and forget if you voluntarily disclosed them and paid all you owed. But voluntary disclosure no longer protects you against prosecution for careless errors that are construed as something worse. Details on p. 69.

ANTI-RECESSION MEASURE now being pushed by Rep. John Fogarty (D., R.I.) would pour Government money into hospital renovation and construction. Both the hospitals and the nation's "sagging economy" need such a spur, he holds. Washington observers say he may win interest-free loans for hospitals, plus millions more in Hill-Burton construction grants.

COLLECTIVE BARGAINING by A.F.L.-C.I.O. unions this spring will be pointed sharply toward health plan improvements. They got them in 40% of all negotiations last year, expect to do better in 1958. Of the trends they'd like to accelerate, "most notable has been the addition of doctor's care at home or office."

BLUE SHIELD SLOWING DOWN: Enrollment gains in recent months have been the smallest recorded across the country since 1948.

TAX RELIEF ON RETIREMENT SAVINGS has run into a roadblock in Congress. When asked why, Doctor-Congressman A. L. Miller (R., Neb.) says frankly: "The Jenkins-Keogh bill smacks just a little too much of a subsidy for physicians. There's a feeling in Congress that this bill is tailored especially for them. Personally, I favor it. But I just don't think we'll get it out of committee."

HAS YOUR HOSPITAL a committee on infections? Though not required now for accreditation, it will be soon, says Dr. Kenneth Babcock of the Joint Commission.

WHEN IS A FEE UNCONSCIONABLE? When it's scaled up beyond the "practical value" of the physician's services, because of the patient's ability to pay. Says a new ruling from the A.M.A. Judicial Council: "Ability to pay is a secondary factor, one to be considered after, not before," the value of the services rendered. "Their practical value lies within a range—within limits above or below which a fee is unconscionable."

NEWS BRIEFS

WHO SHOULD PAY the soaring costs of state medicine in Britain: the sick or the well? The well, according to the Government. This July it will raise taxes rather than raise the scheme's on-the-spot charges to patients.

THIS IS A GOOD TIME to start thinking about buying or building a house. Mortgage money is available again at lower interest rates. And Congress may soon reduce down-payment requirements on F.H.A.-insured mortgages so you can buy a $35,000 house for $7,000 cash.

TAX COURT RULING sheds new light on the taxability of salaried doctors' extras—meals, lodging, etc.—furnished by the employer for the employer's convenience. Dr. J. Melvin Boykin had to pay income taxes on such extras because his employer (the V.A.) charged him for them. If furnished without charge, they would have been tax-free.

HOSPITAL GIVES FREE CARE FOR LIFE as one part of a precedent-setting malpractice settlement. The beneficiary is a 4-year-old boy who became permanently disabled following an operation at Mt. Sinai Hospital, Minneapolis. His parents sued for $500,000, settled for $50,000 plus the life care offered by the hospital.

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Medical Economics

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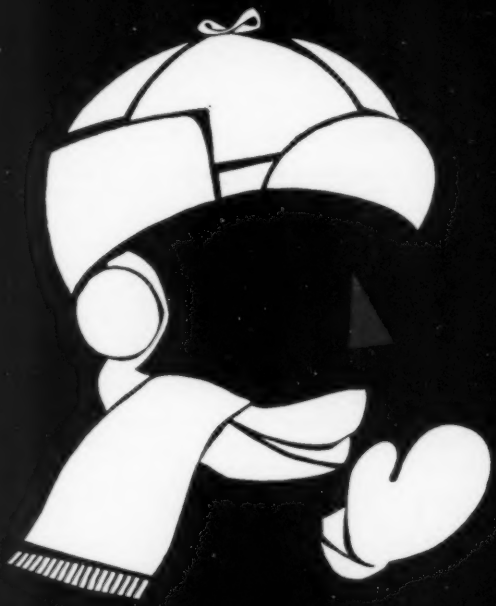

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*Roberts, J. G.: M. Times 84:1232, 1956.

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A few suggestions on how to give your patient a diet he can "stick to"—

The Low Calorie Diet

—and a glass of beer, at your discretion, for a morale-booster

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Letters

Autopsy Requests

SIRS: I would like to add to "The Best Way to Ask for an Autopsy" a method that had proved most successful in our locale:

As you've suggested, promptly after news of the death has been given, the physician in charge should take aside the person who may grant autopsy permission. But the request for the autopsy should then be made in a way similar to that in which a pre-operative permit is requested. The physician's manner should suggest that an autopsy is a *routine* procedure. "Would you please sign this form for examination?" he might ask as he hands the relative the pen. No explanations should be offered unless requested.

Stanley H. Lorber, M.D.
Temple University School of Medicine
Philadelphia, Pa.

Social Security

SIRS: The writer of "Is Social Security a Good Buy?" laid too little stress on one important fact: Social Security coverage doesn't require a physical exam. So it protects many who couldn't buy private insurance.

A doctor's widow with small children to support might find that $200 a month in Social Security benefits buys more groceries than does A.M.A. propaganda.

Milman Pease, M.D.
Brookfield, Mass.

SIRS: Your article conveniently overlooks many of the facts, including the deficit financing of Social Security.

T. M. Trimble, M.D.
Wylie, Texas

SIRS: Bravo! You have done the doctors of this country a great service. This is the most clear-cut and factual picture of the costs and benefits of Social Security as compared to private insurance that I have ever seen.

Ira Leo Schamberg, M.D.
Elkins Park, Pa.

SIRS: Under Social Security, doctors already in their sixties would

get great returns from very small payments. So if doctors themselves are to decide whether to be included in the program, only the younger men should have a vote.

If a young doctor is willing to undertake a lifetime of payments into a scheme that will surely profit older men but that may pay *him* little or nothing, that's his privilege. But it ill behooves us 60-year-olds to ask for a pension plan at the expense of our younger colleagues.

That's why I think *all* articles on Social Security that are written by physicians should state the author's age. Then the reader can judge for himself if the writer is biased.

Garvey B. Bowers, M.D.
Kokomo, Ind.

He Likes the Bed Tax

SIRS: Should physicians and surgeons associated with the closed hospital system be taxed for the use of hospital facilities? Yes, they should!

By a "closed" hospital I mean one to which only members of the attending staff can admit patients. Perhaps such a system *should* lead to efficient administration. But, as it works out, the institution that presumably exists for public good is utilized for private gain. A monopoly is set up for the chosen few —chosen not by competitive examination or a set of qualifications, but by a system of nepotism and favoritism. That this kind of system increases the cost of medical care is evident from a study of any monopoly.

Staff men have to pay for their private office facilities. So why shouldn't they also pay for such ancillary hospital services as utilization of the resident and interne staff, the laboratory, and the X-ray department? If they were taxed in this fashion, hospitals could be run in the black instead of in the red.

M.D., New York

Patient Walk-Outs

SIRS: "Do They Walk Out of Your Waiting Room?" came to my attention when my doctor-employer had the receptionist in our office "take note" of it. The idea is fine for an office working on an appointment basis. Unfortunately, our office isn't run that way.

Many patients are brought in out of turn because they're friends of the doctor. Others must wait two to three hours. It takes tact *plus* to keep patients quiet for that long. I disagree that walk-outs can usually be blamed on . . . receptionists.

R.N., Minnesota

Lay Health Articles

SIRS: As humor, I enjoyed Dr. Theodore Kamholtz's "Where Patients Get Those Crazy Ideas." But I disagree with one of his basic assumptions:

He expresses the naive notion

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that a person who reads about a health problem would consult his doctor if the columnist hadn't intervened. That's most unlikely. Less than half the people seek their first advice from a physician. If what they read induces them to seek medical care—even with wrong ideas about therapy—that's still a net gain. The doctor gets the last word—to the patient's ultimate good.

John E. Eichenlaub, M.D.
Minneapolis, Minn.

Specialists' City Size

SIRS: The figures cited in "How Many People to Support a Specialist?" must have come from out of the blue. The 1950 census lists only eighty cities in the U.S. that have over 125,000 population.

If the figures given in your article are right, many specialists in this country must be starving.

J. Rhodenbaugh, M.D.
Detroit, Mich.

Our population figures weren't for cities, but for areas. Many a small town can draw on the population of the surrounding area of more than 125,000.—ED.

SIRS: With reference to population and specialists, I've found that practicing as an ophthalmologist in a small town (35,000) has many

advantages and some disadvantages.

On the plus side: One has more time to spend with the family and in recreation, since so little time is required to go from home to office and hospital.

On the minus side: There's rarely a good medical library. There are few or no men in the same specialty to confer with. There's little stimulus to write and meager facilities for research.

If medical meetings, teaching clinics, and so forth aren't attended frequently—and they usually aren't in a small town—one is likely to get into a rut.

Walter S. Atkinson, M.D.
Watertown, N.Y.

Psychiatric Benefits

SIRS: Some time ago, you quoted Dr. Eugene N. Boudreau of the National Association of Private Psychiatric Hospitals as saying: "Of the eighty-five Blue Cross plans in the United States and Canada, only five give full coverage of mental and emotional illness. Partial coverage (usually only token benefits) is provided by forty-five plans; and thirty-five plans give no coverage."

But I've recently come across some very different statistics from another source. Says John R. Mannix, director of the Cleveland Hospital Service Association: "Sixty-six of the eighty-six Blue Cross plans in the United States give some kind of mental health benefits at present."

Who's right?

Robert M. Crum
Planning Assistant
Hospital Service Assn. of Western Pa.
Pittsburgh, Pa.

According to the Research Division of the Blue Cross Commission, there are now a total of eighty-five Blue Cross plans in the U.S., Canada, and Puerto Rico. Nine of them, says the Commission, provide full certificate benefits for nervous and mental disorders; forty-eight others provide at least some benefits; and the remaining twenty-eight plans exclude such coverage entirely from their most widely held certificates.—ED.

Enforcing Ethics

SIRS: You quote the A.M.A.'s Judicial Council as holding that the county medical society ought to be the prime disciplinary agency against unethical M.D.s. Let's be realistic! The average county medical society has only thirty or forty members, and it's utterly impossible for this small group to apply sanctions to one of their members —unless he's very *junior*.

Only the A.M.A. or, in a densely populated area, the state medical association, has the size, power, and objectivity to do it.

M.D., Pennsylvania

END

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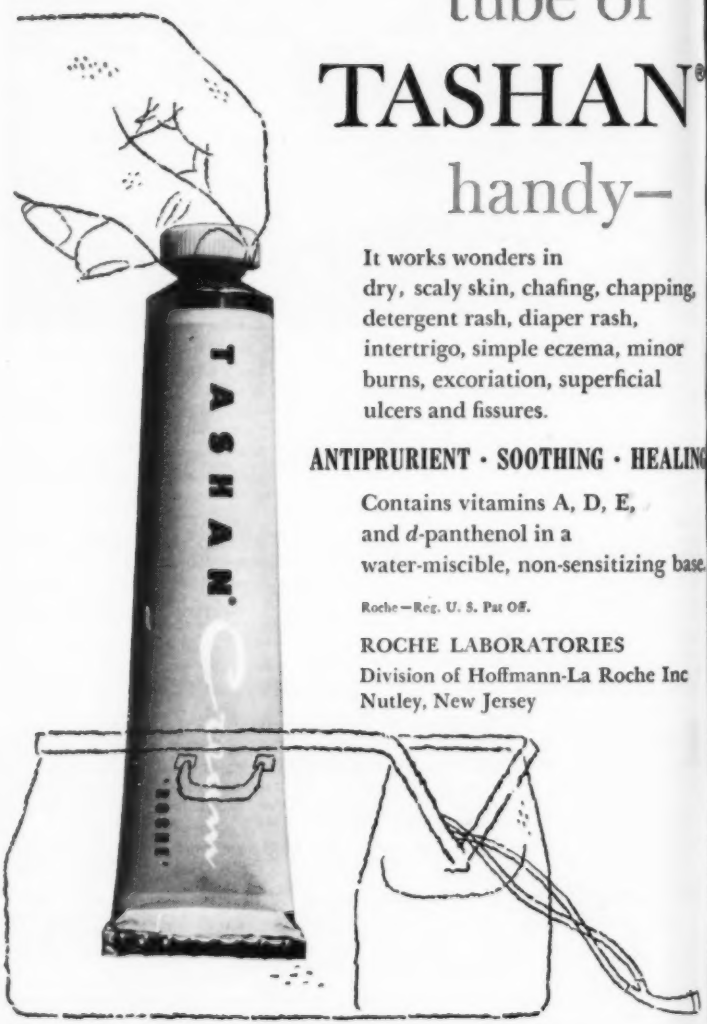

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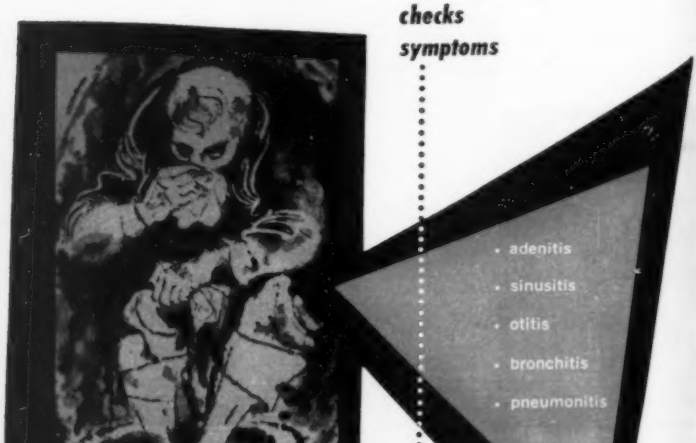

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News

Are You Losing Patients To Emergency Rooms?

Hard-to-get doctors are losing some of their patients to hospital emergency rooms. That's the chief finding of a recent survey encompassing about ninety typical eastern and midwestern hospitals.

Each hospital was asked to report the annual number of emergency-room visits from 1940 to 1955. Average increase over that period: almost 400 per cent. Main reason given for the increase: "the inability of patients to reach [their own] physicians on week-ends, nights, or holidays."

Other reasons cited include the tendency of physicians to use emergency rooms "to accomplish procedures formerly performed in their own offices." Also, "the patient's desire to economize by bypassing the doctor's office."

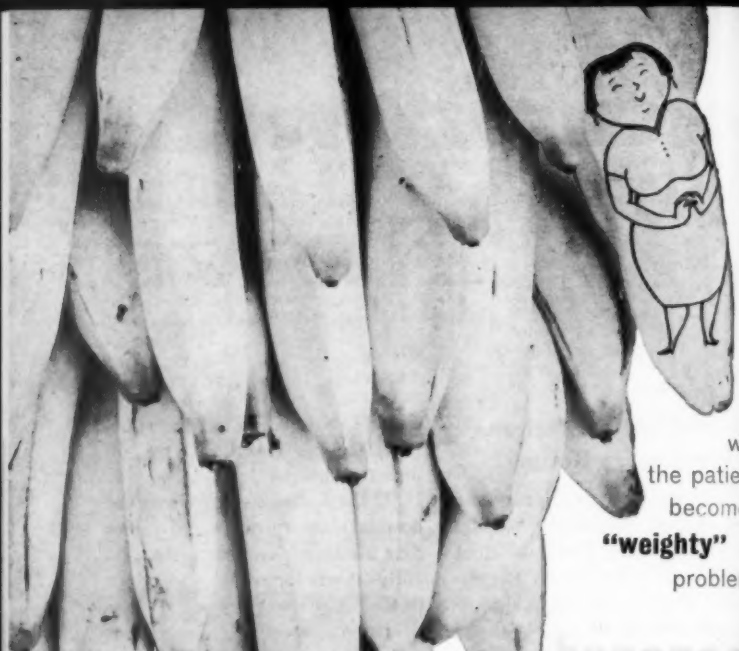
The survey that brought these findings to light was conducted by Dr. Ernest C. Shortliffe, Dr. T. Stewart Hamilton, and Mr. Edward H. Noroian, all of the Hartford (Conn.) Hospital. Here are their conclusions:

"If the doctor . . . proposes the hospital's emergency room rather than his office as an emergency facility—even for trivial and minor procedures—the patient . . . soon comes to regard the emergency room in a similar fashion." So the next time he needs treatment, he may go straight to the hospital "without referring himself to the doctor for his opinion."

Disability Reports Made Easier for M.D.s

When Congress granted Federal disability benefits to qualified persons over 50, private physicians got the job of supplying medical reports on claimants. The job has been a headache. Now it may become slightly less so.

W. L. Mitchell, acting commissioner of the Social Security Administration, recently answered three questions that doctors often



when the patient becomes a **"weighty"** problem

bananas belong in the daily diet

Bananas are just the food to be included in the diet of the patient who needs to lose weight. They stave off hunger pangs and give that "filling feeling." And the "feeling" lasts – for bananas have a staying power high among non-fatty foods.

Better yet, bananas satisfy without fattening, for a medium banana contains only 88 calories. (U. S. Department of Agriculture Handbook No. 8, Composition of Foods.)

Bananas are also rich in taste appeal and per calorie contain more than their quota of most of the vitamins lacking in many weight-reducing diets.

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Help your patient to **greater vitality** – Vitamins A, B_1, B_2, C, and niacin in every banana.

Help your patient to **better digestion** – smooth, bland, bananas contain helpful pectins and non-irritant fibers.

And why not **help yourself to a banana** – they taste so good.

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ask about these reports. Here they are:

"I haven't seen some of my disabled patients in years. Unless I reexamine them, how can I report on their present medical condition?" Mitchell's answer: You're not required to report present medical condition. "The report requested . . . relates to the medical condition at the time the physician last examined the individual."

"That disability report form is a nuisance. Do I have to use it?" No, says Mitchell: "A narrative summary or photocopies of pertinent records are acceptable."

"I spend a lot of time on these reports. Who's supposed to pay for it?" The patient, says Mitchell: "We fully appreciate the feelings of physicians who have to ask for a fee when it is obvious that the patient does not expect to pay for the service. But, as a matter of policy, we require the applicant at his own expense to furnish us with records which reasonably support his claim."

New Answer to the Rural Physician Shortage

How can the shortage of rural doctors be overcome? Maybe by encouraging more young women physicians to become interested in small-town practice. Signs are that they like it and do well at it, according to a recent report in The New York Times Magazine.

"In Virginia," the report says,

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"the woman physician is solving a problem many other farm states face—how to replace the vanishing rural practitioner of the horse-and-buggy era." The Virginia Council on Health and Medical Care first hit on this solution three years ago, when it "discovered that young women doctors were attracted to rural practice by the same factors, working in reverse, that lured young male doctors to the city." Those factors are described this way:

"First, the hospital and clinic doors of urban areas are not so open to young women doctors as to the men, partly because [of] the attitude that medicine is a man's world . . . but mostly because the women medical graduates . . . are hopelessly outnumbered in the scramble for urban places.

"Second, specialization is not nearly so attractive to the women doctors as to men. Long confined to such fields as pediatrics and obstetrics, the women yearn for the broader channels general practice offers."

Capitalizing on these factors, the Virginia council has helped seven young women doctors establish themselves in rural areas. And, the report adds, "the process is still going on. The lady doctors, whose average age is 32, are all doing well . . . Some have married and

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are raising families while continuing to practice."

How do local farmers like their distaff-side doctors? "Their reaction is a healthy one," says the report. "The percentage of male patients of Virginia's lady doctors ranges from 25 to 50 per cent. The women came first. Then they brought the children. Later on, the husbands dropped in . . ."

Doctor Finds Comic-Strip Medicine Is Different

If you ever want to write a medical comic strip, the first thing you'd better learn is that certain parts of the body don't exist. Cleveland Internist Michael A. Petti, creator of the syndicated "Dr. Guy Bennett," reports that "editors view the comic page in an entirely different light from the rest of the paper. It's the last stronghold of Victorian prudery."

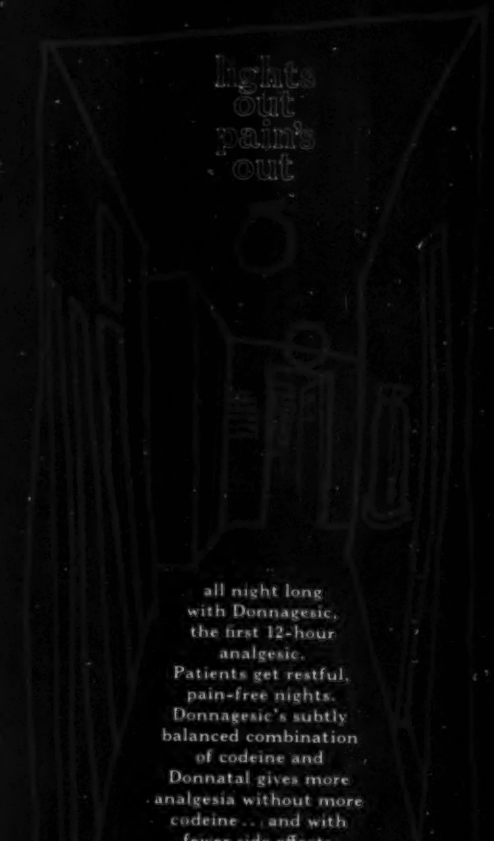
The strip shown here is a case in point. It upset editors from Maine to California. "It taught me," says Dr. Petti, "that doctors live in a world of their own when it comes to discussing bodily functions.

"*Urine*, I discovered, is a horrid, horrid word." Also taboo: Anything dealing with sex or gynecological disturbances.

As to bowels, apparently it's all right to show a picture—so long as you don't talk about it. Nobody complained about a strip in which Dr. Guy Bennett examined an X-ray film of a barium enema. But when he remarked, "The bowel looks O.K.," one editor summarily deleted the word.

But the editors don't always win. "When I did a story on accidental carbon tetrachloride poisoning," Dr. Petti recalls, "I received an indignant letter from a British editor, stating that he wouldn't run the story since it would unduly alarm his readers about the use of a common household substance which he knew was completely harmless. He went on to say, 'I would just as soon drink a shot of carbon tet neat as I would a shot of whiskey.'

"As quickly as I could, I sent him added information on the in-



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DONNAGESIC No. 1 (pink) CODEINE Phosphate ½ gr. 48.6 mg. Hyoscyamine Sulfate 0.1111 mg. Atropine Sulfate 0.0582 mg. Hyoscine Hydrobromide 0.0195 mg. Phenobarbital ¼ gr. 48.6 mg. also available. DONNAGESIC No. 2 (red) containing 1½ gr. 97.2 mg. codeine phosphate. Since one Donnagesic Extentab achieves continuous analgesia for 10 to 12 hours, it replaces 3 equivalent doses of codeine and Donnatal. A. H. ROBINS CO., INC., Richmond 20, Virginia • Ethical Pharmaceuticals of Merit Since 1878

Robins

advisability of drinking carbon tetrachloride 'neat.' I think I convinced him to stick to whiskey. Anyway, he did run the story."

How to Get Better Fee Schedules

With so many fee schedules being negotiated these days—Blue Shield, Medicare, Workmen's Compensation, etc.—doctors need to sharpen up their bargaining techniques. That's what Arizona physicians have been told.

The suggestion comes from a committee headed by Dr. Hayes W. Caldwell of Phoenix. More specifically, the Caldwell committee urges Arizona doctors to take the following steps:

1. Adopt a uniform fee schedule and insist on using it in every third-party-payment program;
2. Hitch this uniform fee schedule to the cost-of-living index;
3. Appoint a single bargaining committee to handle all negotiating of doctors' fees.

Why a uniform schedule? The committee says it would save "long hours of work" for physicians. Another consideration: It would allow private insurance companies "to compete with government insurance plans on an equal basis."

And by adjusting the agreed-on schedule as patients' buying power rose or fell, doctors would avoid "great bargaining hassles," the Caldwell committee thinks. It suggests that "possibly every two years

he fees [should] be re-evaluated... f the cost of living has gone up nore than five points, the fee chedule should be raised."

The advantages of a single bar- aining committee are summed up his way:

Such a committee could "gain reat experience" by bargaining with different groups. It could hear requests for raising and low- ering fee schedules." Finally, it could "consider special lower-in- come groups and possibly charge them some fraction of the agreed- upon fee schedule."

Anti-Malpractice Program Works, Surgeons Find

Can malpractice suits be forestall- ed by a vigorous prevention plan? Two years ago, the American Col- lege of Surgeons decided to find out. Some 2,734 surgeons agreed to cooperate with the program and to buy their malpractice insurance from a single underwriter. Now the first report on the plan has been issued. Its gist: There are clear in- dications of success.

In two years there have been only about one hundred "episodes [of] possible professional liability." And about two-thirds of these epi- sodes "represent precautionary no- tices submitted simply because the [surgeon] has suspected a dissatis- faction on the part of a patient or member of a patient's family." In every case a careful investigation was made; experts advised the doc-

tor on how he ought to behave; and the episode didn't result in a formal claim.

Of the claims that did materialize, twenty were later dropped, thirteen are still pending, three were settled, and exactly one went to trial (the surgeon won). "Provided the present satisfactory loss experience is continued," says the A.C.S., this year the underwriter will probably make a "dividend payment on all policies."

Medical Ethics Bother British Doctors Too

How can G.P.s keep specialists from appropriating referred patients? What should a doctor do when someone else's patient says he wants to switch doctors?

American physicians aren't the only ones plagued by these problems. Each got a thorough airing in England recently, during a symposium conducted by The Practitioner magazine. Here are the solutions proposed:

Rx for patient-stealing: If a specialist treats a G.P.'s patient at home, "every effort should be made to make the occasion a real consultation, [i.e.,] consultant and G.P. should be present together." And any patient treated in a specialist's office "must see his family doctor before and after going to the specialist." This, The Practitioner adds, is not "to protect vested interests." It's to prepare patients for the fact that "if they are

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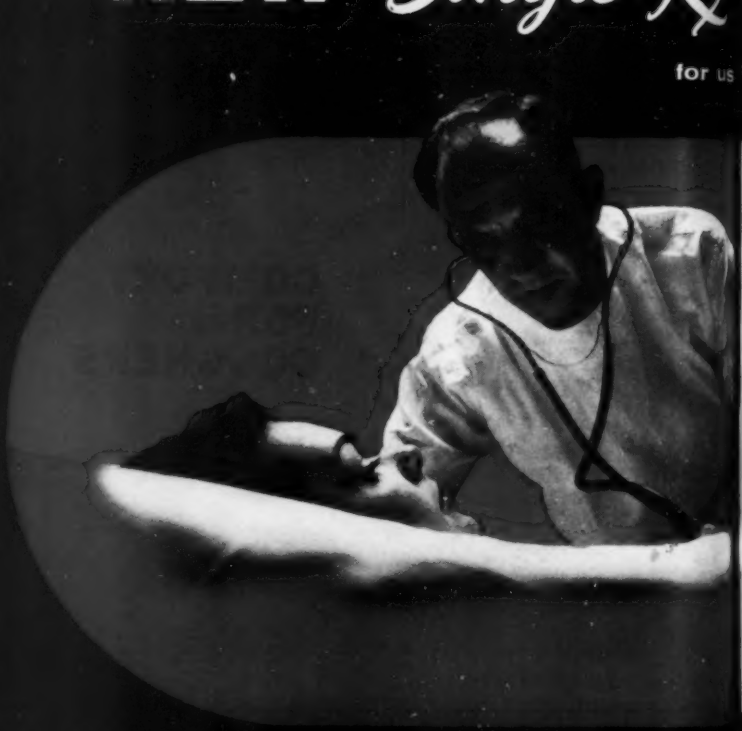

Symptomatic relief of aches, pains, fever, coryza, and rhinorrhea associated with upper respiratory tract infections.

Prevention of secondary pyogenic infections due to tetracycline-sensitive organisms — which often follow viral infections of the upper respiratory tract.

Bristol LABORATORIES INC. SYRACUSE, NEW YORK

taken seriously ill on a Saturday night, it will be the family doctor who will have to treat them and not the consultant."

Rx for doctor-switching: When a G.P. is visited by another G.P.'s patient, he must "refuse to attend until the patient or his relatives" have informed the other practitioner that "a change is desired."

Druggists Sending Many Patients to Doctors

Druggists refer many patients to doctors. In return, they wish doctors would warn patients when a prescription is going to be expensive—but *without* quoting exact prices.

The Health Information Foundation discovered these facts from a survey of 450 druggists. They weren't "typical pharmacists," the H.I.F. points out, but "men who, because they head prescription departments in stores that do a large volume of prescription business, are especially likely to have knowledge of their customers' medical problems."

Because the pharmacist "speaks the layman's language," explains the H.I.F., "people often discuss their medical problems more openly with him than with their doctors . . . More than two-thirds of the druggists maintain that questions about health and medical care come up virtually every day in their stores . . . Questions about children, sore throats, colds, coughs, indigestion, especially if it is late and the doctor's office is closed . . . They often ask about the medicine the doctor has given—what it's for, what to expect of it, how long before they can expect results . . .

"An overwhelming majority of druggists," the H.I.F. continues, "say they can usually tell, when a customer asks a question, if he really needs a doctor. And four out of five pharmacists insist that they always urge such customers to see a physician."

Sometimes the patient doesn't want to see a physician, the H.I.F. reveals. These are the reasons most often cited:

¶ "They're trying to save money." (Cited by 60 per cent of the druggists.)

¶ "They don't want to wait in the doctor's office" or "He's too busy." (Cited by 25 per cent of the respondents.)

¶ "They can't afford the doctor's fee." (Cited by 16 per cent.)

¶ "They don't think it's serious enough." (Cited by 16 per cent.)

What does a druggist do when he's actually asked to recommend a doctor? Reports the H.I.F.:

"The most common procedure is to name several doctors and tell the customer to take his choice . . . Other druggists are less hesitant about sticking their necks out; they

first thought for high b.p.*

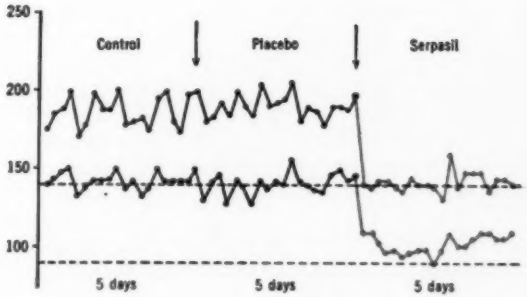

*Chart shows actual response to Serpasil in a patient with benign essential hypertension (data on request). Consider Serpasil® (reserpine CIBA) (1) alone to lower blood pressure gradually and safely in most cases of mild to moderate hypertension; (2) as a primer in severe hypertension before more potent drugs are introduced; (3) as a background agent in all grades of hypertension to permit lower dosage and thus minimize side effects of other antihypertensives. **C I B A**

actually decide which doctor seems best suited to handle a particular customer's case, and recommend that doctor . . .

"Three out of five druggists maintain that they are reasonably familiar with the good and the bad points of the physicians in their neighborhoods."

Eighty-four per cent of the druggists say that "doctors should warn patients in advance when a prescription will be expensive," according to this study. "But only 10 per cent of all druggists feel that the doctor should actually estimate the cost."

Another H. I. F. study indicates that, as a matter of fact, 42 per cent of all doctors *do* estimate the cost of expensive Rxs. Another 51 per cent warn patients that they're likely to be expensive.

New Agency Set to Screen Foreign-Trained M.D.s

Have all the foreign-trained internes and residents you've worked with been of real assistance? Or were some so poorly prepared for American medicine that they were of little help? This month a newly created American medical agency will start screening graduates of foreign medical schools in an attempt to distinguish between the qualified and the unqualified.

The new agency is the Educational Council for Foreign Medical Graduates.* Here, as explained by its executive director, Dr. Dean F. Smiley, is how the screening operation will work:

First the foreign-trained doctor's credentials will be checked. Says Dr. Smiley: "If his credentials show him to be a graduate of a medical school listed in the World Health Organization's directory, he will be approved for admission to the new American Medical Qualification Examinations."

This exam will be a six-hour test of general medical knowledge and command of English. It will be tried out this month on foreign-trained doctors already in America. It will be given again in September—and twice yearly thereafter—here and in as many foreign countries as the council finds necessary.

If he passes this test, the foreign-trained doctor will be certified as qualified to function effectively in an American hospital. From then on he will be considered "on an equal basis with American graduates," Dr. Smiley says. "There is little doubt that he will be able to get an interneship or residency in an American hospital."

What about foreign doctors who fail the test? It's hoped that withholding council certification will

*Sponsored by the A.M.A., the American Hospital Association, the Association of American Medical Colleges, and the Federation of State Medical Boards.

eventually keep them out of the U.S. "We expect the State Department will refuse exchange visitor visas to foreign medical school graduates who are not council-certified," Dr. Smiley explains. If they do enter this country, he expects hospital staffs won't take them.

"But we're not primarily a watchdog to keep foreign doctors out," Dr. Smiley adds. "Our chief function is to serve as an information center and to help both the qualified foreign doctor and American medicine to benefit by his training in our hospitals."

Research Trainees Will Get Blank-Check Aid

Basic medical research is about to get a much-needed shot in the arm. The University of Pennsylvania is sponsoring a new kind of fund, and it may augur a change in attitude on the part of the Government and foundation men who decide how much money gets spent for what.

The Pennsylvania Plan to Develop Scientists in Medical Research, as it's called, will subsidize the budding research *man*—not the disease or the drug.

"Government and private grants focus on projects rather than people," explains a brochure put out by the plan. "They presuppose the existence of trained research people to man the project." Actually, too often such trained researchers don't exist, says the plan. For instance:

¶ "In 1953 . . . the President's Commission on the Health Needs of the Nation reported 200 research and teaching vacancies in American medical schools. Most of the vacancies were in the basic medical sciences . . . Estimates indicate that the vacancies, instead of being filled, have increased now to about 300."

¶ "Early in 1957 an Associated Press story told that the National Institutes of Health had been unable to allocate all the medical research funds appropriated by Congress because there were too few trained scientists to carry on the research projects planned."

¶ "A survey [showed that] only two of the 128 members in the 1957 graduating class of the University of Pennsylvania School of Medicine [intended to] do research in the basic medical sciences."

The trouble, says the Pennsylvania plan, is that young doctors simply can't afford to go into research. What they need is "a financial cushion," it concludes. So it's soliciting industrialists and foundations for the money to provide that cushion.

The plan hopes to help "no more than twenty future scientists in any one year," all of them "candidates of real brilliance." A typical an-

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electrocardiograph

18 lbs
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Everything you need for taking an accurate, permanent, directly-recorded electrocardiogram is now available in a "package" the size of a portable typewriter, and that weighs only 18 pounds! This is the new Model 300 VISETTE — a completely modern, transistorized ECG recently introduced by Sanborn Company. The unique design has made possible for the first time a clinically *accurate* instrument that is *truly* compact and fully portable.

By actual use — in your own examining room, in your patient's home, at a hospital — you can discover the Visette's value and portability. Convenience of *use*, greater ease of *operation* — and even simpler, faster *servicing*, should the need arise — comprise the design concept of this instrument.

A comprehensive folder describing the Model 300 VISETTE electrocardiograph is available on request. Or call the Sanborn Company Branch Office or Service Agency in your locality for a demonstration in your office — to see for yourself the advantages of owning the ECG that "brings 'cardiography to your patient."

The established Sanborn Model 51 Viso-Cardiette is also available for those who prefer a larger, heavier (34 lbs.) instrument — $785.00, delivered. Many doctors use their "51 Viso" in the office and the Visette on "cardiograph calls."

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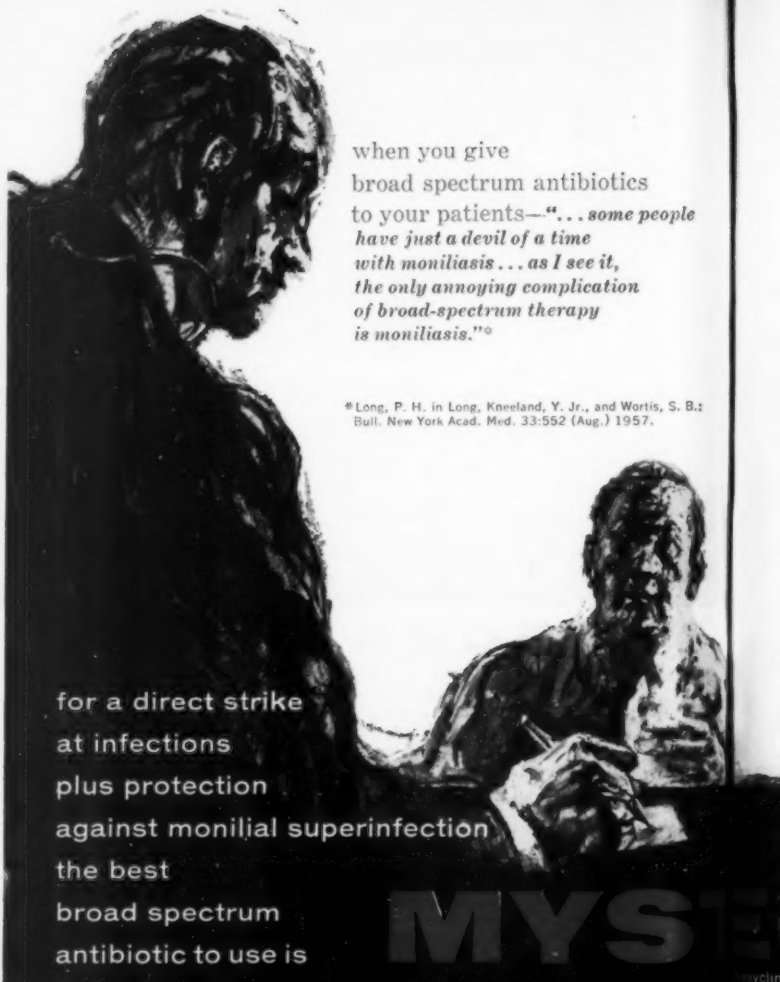
when you give
broad spectrum antibiotics
to your patients—"... some people
have just a devil of a time
with moniliasis ... as I see it,
the only annoying complication
of broad-spectrum therapy
is moniliasis."*
* Long, P. H. in Long, Kneeland, Y. Jr., and Wortis, S. B.: Bull. New York Acad. Med. 33:552 (Aug.) 1957.
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at infections
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Mysteclin-V provides you with a dosage form for every clinical need:

	Tetracycline phosphate complex equiv. tetracycline HCl (mg.)	Mycostatin (units)	Packaging
Capsules (per capsule)	250	250,000	Bottles of 16 and 100
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1. Mysteclin-V contains Sumycin—Squibb Tetracycline Phosphate Complex—for faster, higher initial blood levels . . . for more rapid transport of more tetracycline to the site of the infection.
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nual budget, it hopes, could be about $6,000 for living expenses for the trainee and his family, plus another $1,500 for laboratory equipment and supplies.

Charity Patients Prepay Some Hospital Costs

Charity patients are supposed to pay what they can toward their hospitalization costs. Usually, of course, they pay nothing. But not in Memphis, Tenn. A novel way of putting charity patients on a part-pay basis is being tried out there.

Until 1952, patients in Memphis city hospitals paid all or nothing. Then the hospitals began charging people according to ability to pay. Robert C. Hardy and Richard L. Durbin, Memphis hospital administrators, explain in a joint report that "this is a fine policy as far as it goes . . . [But] it just doesn't go far enough . . . After fifty years of free care, it is difficult for the clientele to get used to the idea of paying."

So today Memphis is going one step further. "All users of the municipal hospital facilities have been notified that if they are able to pay any portion of their hospital care, they must carry hospitalization insurance in an amount commensurate with their financial situation," Hardy and Durbin report. MORE▶

"Doctors can't help shingles?"

Physicians who have used PROTAMIDE extensively deplore such statements as unfortunate when they appear in the lay press. They have repeatedly observed in their practice quick relief of pain, even in severe cases, shortened duration of lesions, and greatly lowered incidence of postherpetic neuralgia when PROTAMIDE was started promptly. A folio of reprints is available. These papers report on zoster in the elderly—the severely painful cases—patients with extensive lesions. PROTAMIDE users know "shingles" *can* be helped.

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How much insurance is "commensurate? The following scale has been worked out:

Individual's Monthly Income	Family's Monthly Income	Insurance Coverage Required
Below $50	Below $150	None
$51-75	$151-175	Type A
$76-100	$176-200	Type B
$101-200	$201-325	Type C

Individuals earning more than $200 a month—and families earning more than $325—are not eligible for admission. Those who are eligible must take out the insurance indicated. All three types of insurance provide thirty days' coverage. Type A pays the hospital a minimum of $3 a day for room and board, $30 for all other expenses; Type B pays $5 and $50; Type C pays $8 and $80. Any additional costs are still paid by local taxpayers. The insurance may be bought either from Blue Cross or from one of the commercial companies.

How has the public reacted? Favorably, thanks to the way in which Memphis initiated its new program:

First there was a three-month "buy your insurance" campaign. "Cards explaining the new requirements were given to each patient visiting the clinic," Hardy and Durbin relate. "Large, curb-yellow posters . . . were placed in the waiting rooms of the hospitals and clinics." Spot announcements over radio and television helped spread the word.

Newspaper support also helped. One newspaper commended the plan because it "discourages the easy riders and freeloaders." Another noted that "Memphis will always provide a free ride for those who really deserve a free ride." And since many Memphis charity patients are Negroes, hospital people there were especially gratified when the Negro press endorsed the idea. Wrote a columnist in the Negro Tri-State Defender:

"Too many colored folk have been observed riding up to the John Gaston Hospital in late-model cars . . . If Negroes can meet those high car notes, they should be able to pay comparatively low hospitalization insurance rates."

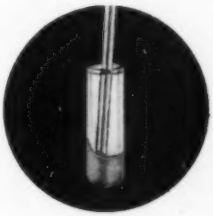
'Sickest-Looking Jewelry' Is a Healthy Business

Radiologist Robert G. Zach of Monroe, Wis., has always liked jewelry-making as a hobby. Several years ago, he turned out some cuff links and tie pins with clinical designs on them. Then he turned out some more for his physician-friends—and still more for *their* friends. Today he's the head of a small industry that gives spare-time employment to no less than nine of his former patients.

Dr. Zach sells what he proudly labels, "The World's Sickest-Look-

your office: **IT'S THIS EASY!**

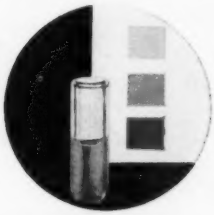
1. Add 4 drops serum or plasma to one PHOSPHATAB tablet in special tube.



2. Crush tablet.

3. Let stand at room temperature 12-30 minutes. (time from chart)

4. Add 1 drop of color developer: mix.



5. Compare color.

For the First Time: STAT ASSURANCE In These Common Diagnostic Problems:

Uncertain bile duct involvement

Questionable retained stones in the bile duct

Obscure neoplasms of liver, bone or pancreas

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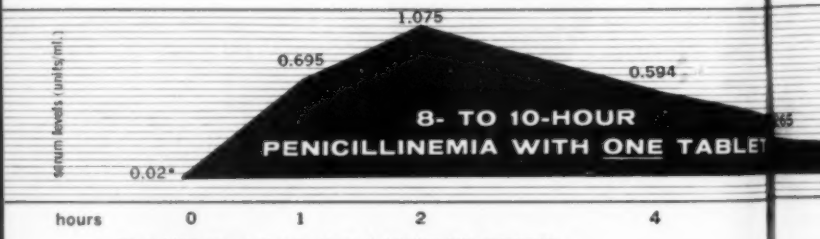

*Bactericidal concentration for Group A beta-hemolytic streptococci-experimental infections in mice (Eagle, H., and others: Am. J. Med. 9:280 [Sept.] 1950).

- permits fewer doses
- gives immediate blood levels
- prolongs blood levels with one tablet q. 8 hours
- resists gastric destruction

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Supplied: Tablets, 250 mg. (400,000 units), vials of 24.

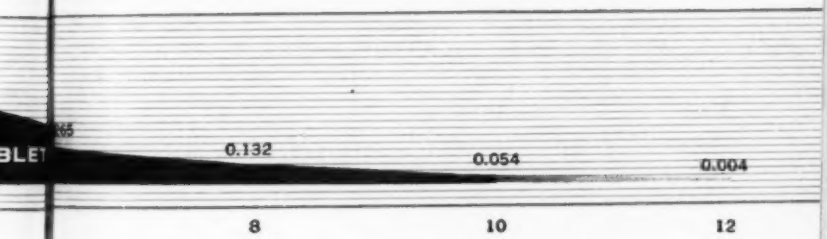
ORAL PENICILLIN

PEN·VEE® L-A

Penicillin V, Crystalline, Wyeth
(Phenoxymethyl Penicillin)

LONG-ACTING

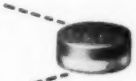
EL WITH ONE TABLET q. 8 HOURS



a new continuous-action principle

2-layer tablet

The penicillin V in this half is rapidly released and absorbed—gives immediate blood levels



The penicillin V in this half is slowly released and absorbed—gives protracted blood levels

PHYSICIANS' COUNCIL · INFORMATION ON CHILD HEALTH ·

This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Child Health.

ing Jewelry." Designs include a heart with coronary infarct, a gastric resection with or without marginal ulcer, a barium enema with diverticulosis of the colon, a molar tooth with roots reaching clear to the testes, and over fifty other clinical miniatures. They're all hand-carved and set in gold plate.

"And they're anatomically perfect," explains Dr. Zach proudly, "so doctors can diagnose the diseases present."

He has never done any advertising. He hasn't had to. One way or another, several thousand physicians in every state and several foreign countries have learned about Dr. Zach's jewelry and have sent him orders. "They must find it valuable as a conversation piece," he says.

How One Doctor Handles Hospital Trustees

"Every member of every board of trustees should witness one autopsy, should see at least a couple of babies born, and should stand in the amphitheater and see some surgery." This formula is offered by Dr. Anthony J. J. Rourke, a hospital consultant, as the quickest way to give hospital trustees "a little more insight" into doctor's problems.

"I did it with trustees of one hospital," he recalls. "It was the most exciting and intriguing thing that the board of trustees ever went through. One member of the board, as I remember, sneered at the doctors a little. I went with him when he visited the operating room. It was a wonderful experience... His attitude changed completely."

Board Certification Isn't Good Enough, He Says

Subspecialization in surgery has now reached the point where "no surgeon should be given unlimited privileges in any specialty." So says one hospital authority.

Dr. Charles U. Letourneau points out that nowadays "some surgeons dedicate a lifetime . . . to perfecting one or two surgical operations in a particular region of the human body . . . It is a travesty for a surgeon untrained in such operations to attempt them."

The certification boards weren't fully recognized until the late Thirties, Dr. Letourneau observes. Then it was decided "that a board-certified surgeon might have unlimited privileges in his own specialty." But in the twenty years since then, he remarks, "it has been noted that some board-certified surgeons fail to keep up to date with the latest developments."

Dr. Letourneau's solution: Let hospital committees certify each doctor for the procedures he can do. And let them disregard whether or not he's a board man. END

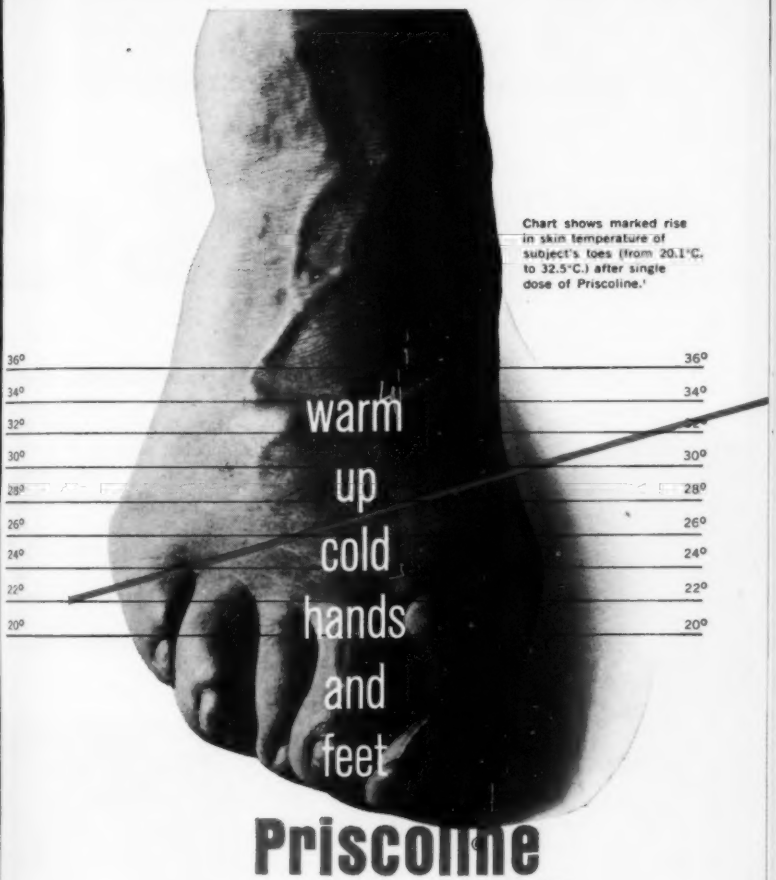


Chart shows marked rise in skin temperature of subject's toes (from 20.1°C. to 32.5°C.) after single dose of Priscoline.[1]

Priscoline

hydrochloride

(tolazoline hydrochloride CIBA)

When elderly patients complain of cold sensitivity in the extremities, impaired circulation can be suspected. In such cases consider the proved ability of Priscoline to increase peripheral circulation. "Priscoline was the most consistent and most effective vasodilator of several agents compared . . ."[1]

1. Reedy, W. J.: J. Lab. & Clin. Med. 37:365 (March) 1951.

SUPPLIED:

TABLETS, 25 mg. (scored).

ELIXIR, 25 mg. per 4-ml. teaspoon.

MULTIPLE-DOSE VIALS, 10 ml., 25 mg. per ml.

CIBA

SUMMIT, N. J.

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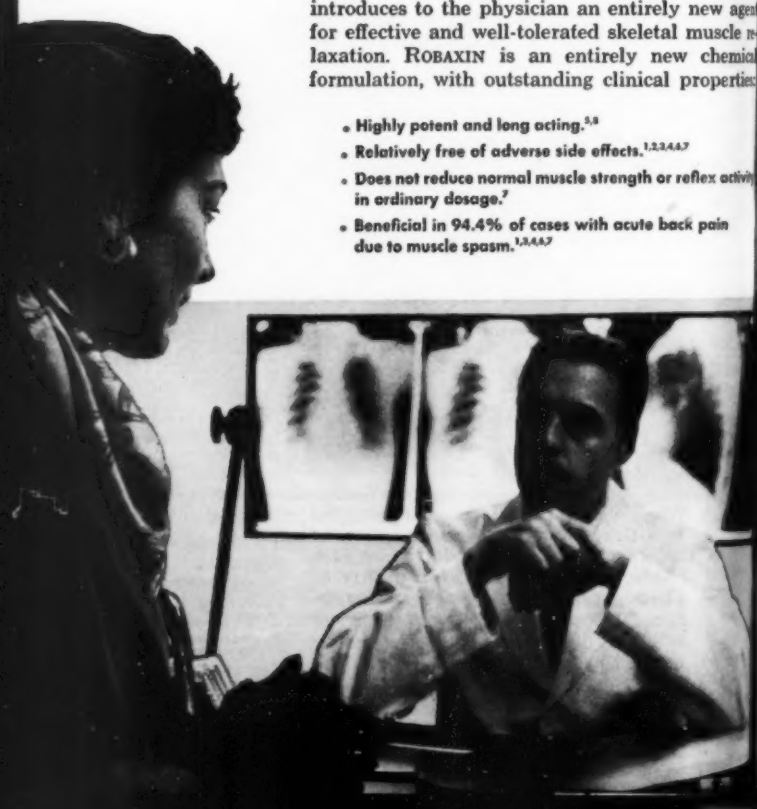
A NEW SKELETAL MUSCLE RELAXANT

Rob

ROBAXIN – synthesized in the Robins Research Lab-
oratories, and intensively studied for five years–
introduces to the physician an entirely new agen
for effective and well-tolerated skeletal muscle re-
laxation. ROBAXIN is an entirely new chemica
formulation, with outstanding clinical properties

- **Highly potent and long acting.**[5,6]
- **Relatively free of adverse side effects.**[1,2,3,4,6,7]
- **Does not reduce normal muscle strength or reflex activity in ordinary dosage.**[7]
- **Beneficial in 94.4% of cases with acute back pain due to muscle spasm.**[1,3,4,6,7]



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Highly specific action

ROBAXIN is highly specific in its action on the internuncial neurons of the spinal cord – with inherently sustained repression of multisynaptic reflexes, but with no demonstrable effect on monosynaptic reflexes. It thus is useful in the control of skeletal muscle spasm, tremor and other manifestations of hyperactivity, as well as the pain incident to spasm, without impairing strength or normal neuromuscular function.

Beneficial in 94.4% of cases tested

When tested in 72 patients with acute back pain involving muscle spasm, ROBAXIN induced marked relief in 59, moderate relief in 6, and slight relief in 3—or an over-all beneficial effect in 94.4%.[1,3,4,6,7] No side effects occurred in 64 of the patients, and only slight side effects in 8. In studies of 129 patients, moderate or negligible side effects occurred in only 6.2%.[1,2,3,4,6,7]

Indications – Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and miscellaneous conditions, such as bursitis, fibrositis, torticollis, etc.

Dosage – *Adults:* Two tablets 4 times daily to 3 tablets every 4 hours. Total daily dosage: 4 to 9 Gm. in divided doses.

Precautions – There are no specific contraindications to Robaxin and untoward reactions are not to be anticipated. Minor side effects such as lightheadedness, dizziness, nausea may occur rarely in patients with unusual sensitivity to drugs, but disappear on reduction of dosage. When therapy is prolonged routine white blood cell counts should be made since some decrease was noted in 3 patients out of a group of 72 who had received the drug for periods of 30 days or longer.

Supply – Robaxin Tablets, 0.5 Gm., in bottles of 50.

References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:274, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and Little, J. M.: J. Pharm. & Exper. Therap. 119:161, 1957.

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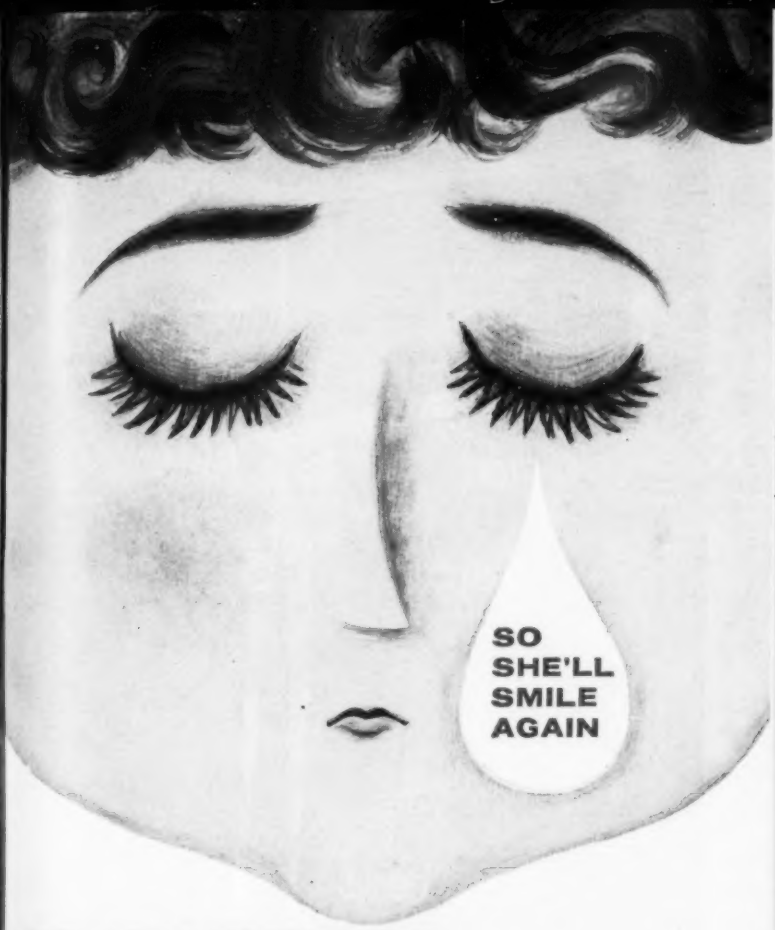

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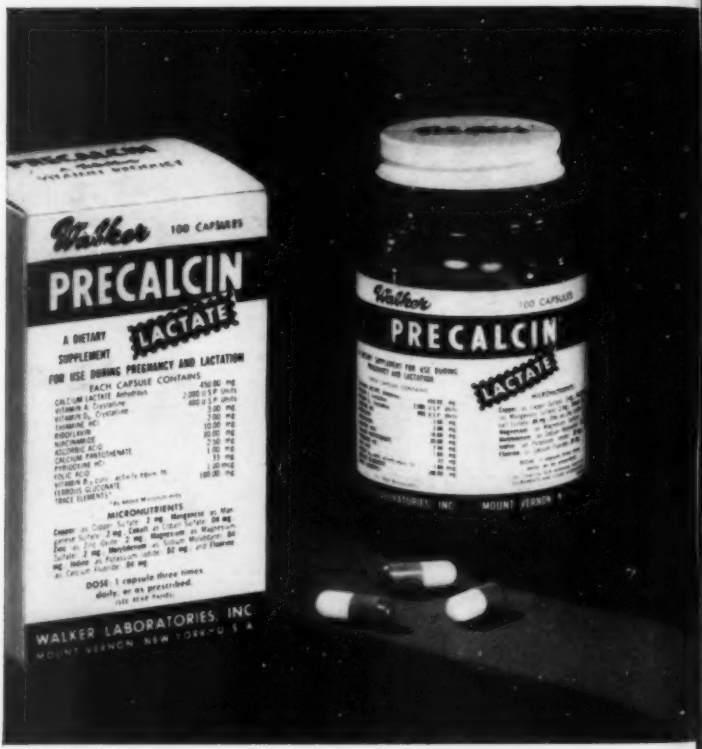

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, MAR. 17, 1958

When Does a Tax Error Become Tax Evasion?

By Allan J. Parker, LL.B.

In one recent year, 1,500 Americans got prison sentences totaling more than 2,800 years for deliberately evading payment of all or part of their Federal income taxes. A good many others were heavily fined. A substantial number got both sentences and fines.

Some of them were racketeers. But most were respectable citizens. In finding them guilty of fraud, juries or judges supported the Treasury's contention that these persons had knowingly tried to cheat the Government.

None of which concerns you? You wouldn't dream of deliberately underpaying your taxes?

Probably not. But what if you make a careless mistake in filling out your Federal income tax return? Unfortunately, a number of doctors have found that the tax men may interpret such carelessness as willful evasion. To

illustrate how fine a line there is between legitimate tax avoidance and illegitimate tax evasion, let's look at a few real-life cases. First, we'll review a case of obviously deliberate evasion, then one that clearly involved carelessness. Finally, we'll glance at a couple of borderline cases where even the tax experts had trouble deciding whether the doctors had erred on purpose.

To begin with, here's the black and white of the income tax error-or-evasion question:

Black: The income tax returns of a certain Missouri doctor indicated he'd earned about $39,000 over a three-year period. On the surface, there was nothing to dispute his statements. An aide had filled in his daily cash-payment records; a certified accountant had prepared his tax returns. But an investigation by Government agents showed that the physician had regularly rewritten his office

"The A.M.A. will hear about this!"

cash records. In the process, he'd failed to include cash payments totaling $61,000.

There was no question of careless error here. So the doctor was slapped with fines and penalties that amounted to almost as much as his back taxes.

White: The residents of one Eastern community call their water bills "water taxes." So, without giving the matter a second thought, a local physician habitually included his home water bills among the deductions for local taxes that he took on his Federal tax return.

Such bills aren't taxes, of course. They can be legally deducted only as a professional expense for an office building. When revenue agents spotted the doctor's error, they told him he owed the Government money. But since this sort of error indicated mere thoughtlessness on the doctor's part, he wasn't accused of fraud.

Now for the grays:

Do you remember the case of Dr. Dufek that was recently reported in this magazine?* Dr. Dufek was an unusually busy practitioner in a tiny Southern town. He apparently couldn't find a competent business manager. For years he maintained a hit-or-miss bookkeeping system. As a result, he regularly understated his income on Federal tax returns.

When finally charged with fraud, the doctor insisted he hadn't known he'd paid less than he should have. He claimed to have done the best he could with the time and help he had. And the story as he tells it rings true.

His errors were so flagrant, though, that U.S. attorneys said they were prepared to prove fraud and his lawyer advised him not to fight the case. The doctor is now faced with the prospect of fines and back taxes amounting to $40,000. Evidently, the Treasury sees no excuse for carelessness that extends over a period of years—always to the taxpayer's benefit.

Perhaps Dr. Dufek's story would have had a happier ending if he himself had called his errors to the attention of the T-men. Consider this story:

An Ohio doctor filed a return showing his gross income as $5,000. Later, he discovered his income had actually been

*"Dufek" isn't the doctor's real name. See "They've Called Me an Income Tax Evader," MEDICAL ECONOMICS, November, 1957.

$31,000. He quickly hired an accountant and filed an amended return. None the less, he was brought to court. There he gave an explanation much like Dr. Dufek's: He'd worked day and night; he'd received many fees in cash; he'd been unable to hire a competent aide to handle his bookkeeping.

The court was impressed. It took into account the fact that he'd hastened to correct his error as soon as he discovered it. So his first return was deemed careless, not fraudulent.

What both the above cases indicate is that if a mistake is big enough, the taxpayer is almost certain to be suspected of fraud. His explanation had better be good if he wants to avoid standing trial, particularly if his errors have been frequently repeated.

"All right," you may say. "I understand the perils of carelessness. But I'm not too worried about them. I'm meticulous in filling out my returns."

Are you sure? A former official of the Internal Revenue Service says that three out of four physicians with incomes of over $10,000 make tax mistakes.

Obviously, most such mistakes aren't deliberate and wouldn't be termed so. Still, the only sure way to avoid having errors construed as deliberate evasion is not to make them. In this connection, there are two bits of advice that you've probably heard again and again. They're still worth repeating:

1. Keep complete day-by-day records of all cash received.

2. Employ a competent tax adviser and follow his recommendations.

What if even your adviser isn't sure whether you must legally declare a given item? If you decide not to pay taxes on it, you'd better explain your reasons in your tax return. For example:

Let's say you did a major operation last year on the wife of a colleague. In token of their gratitude for your unpaid services, the doctor and his wife sent your wife a Christmas present of a $1,000 mink stole.

You believe the gift nontaxable, and you're probably right. Even so, since your families don't ordinarily exchange Christmas gifts and since this was an unusually expensive one, you'll avoid possible trouble if you attach an explanatory rider to your return for 1957. On it you should

make a full disclosure of the circumstances surrounding the gift.

The tax men may disagree with your decision not to declare the value of the fur as income. But at least they can't possibly accuse you of fraud.

What if you discover you've made a mistake after you've already filed your return? Again, it's probably well to tell the I.R.S. about it. But if the mistake is really serious, consult first with your *attorney* (not your accountant or other tax adviser). Your conversation with him alone will be legally safe from Government investigation. And he'll have the best idea of how to make the proper move under the circumstances.

The law used to forbid criminal prosecution of a man who'd voluntarily disclosed an income tax error. That's no longer the case. Voluntary disclosure is only one extenuating—though important—factor in favor of the taxpayer.

In other words, to err may be human. But the U.S. Treasury is far from divinely forgiving. END

Why Worry?

I'm with a group of pediatricians. The other day a mother brought in her son Herbert, an obese boy of 12. She was worried as to whether Herbert's testes were normal. The examining doctor assured her they were.

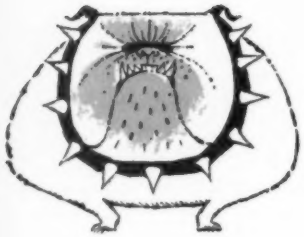
Evidently she wasn't convinced. She took the boy to another physician, outside our group. He told her that Herbert had undescended testes, and he prescribed injections.

She stormed back to us to tell us of our error. Our senior man heard her out. Then *he* examined Herbert. After finding the testes normal, he called the mother into the examining room.

"You can see for yourself you don't have to worry about Herbert," he told her. "There's no reason here why you shouldn't be a grandmother some day."

"Not me," said the mother. "Herbert's going into the priesthood."

—M.D., CALIFORNIA



Grievance Committe

In doctor-patient disputes, this committee's determination of a fair fee is binding on medical society members. They can be expelled if they don't accept it

By Clifford F. Taylor

A few years ago, the medical society's mediation committee in Buffalo, N.Y., woke up to the fact that it couldn't settle doctor-patient disputes by the mere power of suggestion. For one thing, it couldn't compel an unwilling doctor to appear before it. Nor could it force a society member to adjust a fee it considered out of line.

"Two incidents within a few months made it apparent that the committee was like a toothless watchdog—one that could bark but couldn't bite," says Dr. Max Cheplove, the committee's first secretary. "So the committee determined to *get* teeth. And we did."

What were the two incidents? How did the grievance-committee doctors gain the power to enforce their decisions and thus to prevent further frustrations in the realm

...itte...With Teeth

of professional self-discipline? The story may well inspire physicians elsewhere to do likewise. Here it is:

In the summer of 1953, a woman brought what seemed a minor complaint to the Erie County committee. After being treated by one doctor for three successive genital abscesses, she had changed physicians. The new man had found she needed an operation and had removed a six-pound tumor and her Fallopian tubes. Meanwhile, she'd paid the first physician $10 for his last treatment; he'd promised to refund the money if Blue Shield paid him his total bill of $35.

Blue Shield paid up, but the doctor refused to do so unless the woman would come to his office to pick up the money. When he rejected her request to mail her the $10, she took the matter to the mediation committee.

Much ado over $10? Perhaps. Still, the doctors on the committee realized that the case involved more than a mere sum of money. So they asked the doctor either to mail the patient her $10 or to come before the committee and explain his stand.

He did neither. He simply ignored the committee's re-

peated appeals. And there was nothing the doctors could do about it.

"We were equally powerless in a case that turned up several months later," says Dr. Cheplove. "This time it was a question of fee adjustment."

The doctor in the case had given emergency treatment to an 11-year-old boy who'd suffered an eyelid laceration in an automobile accident. The physician had put in three sutures, had later removed them, and had given the boy a complete refraction. His bill: more than $500.

The patient's mother had paid over $100, but evidently not fast enough to suit the physician. He'd turned the account over to his lawyer for collection. Whereupon the woman brought her troubles to the mediation committee.

Thorough investigation of the case convinced the doctors the bill was excessive. Furthermore, the patient's family was in bad financial straits. So the committee recommended that the doctor cancel the balance of his bill (about $400).

Instead of acquiescing, he instituted suit for immediate payment. Once again, the committee was powerless to enforce its decision.

How did the doctors solve their problem? By urging—and getting—two important changes in their medical society's bylaws.

The first change was put through without a qualm. Erie County's physicians quickly adopted an amendment giving their mediation committee the power to require any society member to appear before it. The penalty if he refused to cooperate: suspension or expulsion from the society.

But the second aspect of the problem gave the committee doctors pause. They didn't *want* the power to set fees. Still, they realized that without real authority, they couldn't help protect patients against the occasional fee-gouger.

The A.M.A.'s Opinion

So they sought an opinion from the A.M.A. Law Department. The department pointed out that organized medicine has no built-in power to crack down on doctors who demand excessive fees. But, the lawyers added, any medical society that wants to discipline its members

for overcharging may amend its bylaws accordingly.

The doctors decided to do so. Their colleagues went along with them. The resultant amendment to the society's bylaws gives the mediation committee full power to determine a fair fee in any case brought to its attention. It can now recommend expulsion from the society for any practitioner who flouts its will.

"Today the committee has the strength it needs to make its decisions stick," says Dr. Elmer T. McGroder, chairman of the committee. "And relations between doctors and the public in Erie County are better because of it."

The six-man committee doesn't overuse its new powers. The doctors consider that their primary job is to conciliate and explain rather than to discipline.

As with every grievance committee, most of the complaints they hear turn out to be unjustified. Fee complaints usually arise, the doctors have found, from physicians' failure to tell their patients exactly what they're charging for, and why. In such instances, the committee does the job of explanation.

Because it *does* have power, it's more conscientious than ever in its investigation of cases. And it now gets full cooperation from medical society members —a cooperation it couldn't always expect in the toothless old days. For instance:

A patient recently complained her doctor had charged $500 for removing a soft tissue ridge caused by another man's rhinoplasty. Since she claimed that before the operation the doctor had set $100 as the fee, the committee immediately asked the man in question to come in and state his case. He willingly appeared and told this story:

Dissatisfied with her earlier operation, the woman had wanted a complete nose reshaping. She carried no insurance. So he'd taken great pains to see that she understood the total cost of the operation in advance, including the hospital bill.

Doctor Upheld

The committee's investigation supported the facts as the doctor had presented them. His fee was adjudged reasonable; and the patient was so informed.

But when, as happens sometimes, the doctor is in the wrong, the committee unhesitantly tells

him so. He then either adjusts his fee or faces expulsion from the society.

Not long ago, a man complained about what he felt was an excessive bill for the removal of a cyst. The doctor justified the fee by explaining to the committee that he'd done a far more complex job than the patient realized. When informed of the doctor's response, the plaintiff insisted there'd been no such complicated operation.

Records Said 'Too High'

To get at the truth, committee members went to the hospital where the operation had been done. There, a study of operative and pathologic reports showed that the doctor had overstated his case. What he'd done had been of a relatively minor nature, for which his fee seemed much too high.

Confronted with the committee's findings, the red-faced physician had no choice but to scale down his bill.

Fewer Complaints Now

Thus, the county's doctors, as well as their patients, have come to realize that the mediation committee is determined to do its job thoroughly. As a result of its fairness in arriving at decisions, and its power to enforce them, complaints from patients have slacked off recently.

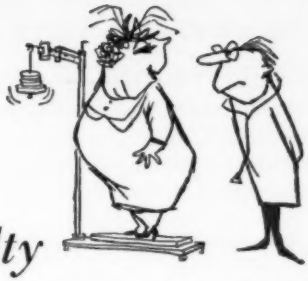
A few local physicians may resent the committee's new set of teeth. But the great majority agree that it's good for the whole profession. END

It's Her Life!

After a female patient of mine had agreed to a laparotomy, I asked her if she had insurance. She said she had and would bring in her policy.

The day of the surgery, she brought it in, all right. "But," I said in surprise, "this is a *life* insurance policy!"

"Why, of course," she said. "You *are* going to operate on me, aren't you?" —JACK E. USEEM, D.O.



The Subspecialty You've Overlooked

Weight reduction is now a $250,000,000 business. Only a few M.D.s are getting their share. Yet it's easy to do, those few say

By William N. Jeffers

What with prosperity, supermarkets, TV, emotional strain, and other inducements to overeating, more and more Americans are getting fatter and fatter. At the same time, they're growing increasingly aware of the probable connection between obesity and such ailments as diabetes and heart disease. So doctors' offices ought to be bulging with overweight patients.

Is this the case? Not at all. The public spends an estimated $250,000,000 annually on reducing pills, appliances, and salons, most of them of questionable value. But relatively few people consult doctors about the problem. One reason why has been stated by Dr. George L. Thorpe, chairman of the A.M.A. Section on General Practice:

"Doctors have been so preoccupied with the problems of trauma and disease that they've ignored the public's growing interest in the problem of excess weight,"

he says. "The average doctor seems to feel that treating patients for obesity is too time-consuming and unrewarding to make it worth-while."

This feeling isn't justified, according to the medical men who've made obesity a major part of their practice. MEDICAL ECONOMICS recently interviewed

A Basic Library on Weight Reduction

Almost any doctor who wants to start treating obesity as a major part of his practice needs refresher reading. The following books are recommended by men established in the field:

A HANDBOOK OF DIET THERAPY. By Dorothea Turner. University of Chicago Press, 5750 Ellis Ave., Chicago 37, Ill. $3.50.

DISEASES OF THE METABOLISM. By Garfield G. Duncan, M.D. W.B. Saunders Co., 218 W. Washington Square, Philadelphia 5, Pa. $15.

MAYO CLINIC DIET MANUAL. W. B. Saunders Co., 218 W. Washington Square, Philadelphia 5, Pa. $5.50.

MODERN NUTRITION IN HEALTH AND DISEASE. By Michael G. Wohl, M.D., and Robert S. Goodhart, M.D. Lea & Febiger, 600 S. Washington Square, Philadelphia 6, Pa. $18.50.

NUTRITION AND DIET IN HEALTH AND DISEASE. By James S. McLester, M.D., and W. J. Darby, M.D. W.B. Saunders Co., 218 W. Washington Square, Philadelphia 5, Pa. $10.

several such men, most of whom are internists. Their consensus:

A special interest in weight reduction is professionally satisfying, since the victim of obesity is in real need of help. It also shortens the work day, because the overweight patient seldom needs hospitalization or house calls. It's especially rewarding in

OBESITY: ITS CAUSE, CLASSIFICATION, AND CARE. By E. Philip Gelvin, M.D., and Thomas H. McGavack, M.D. Paul B. Hoeber, 49 E. 33rd St., New York, N.Y. $3.50.

OBESITY: THE GENERAL PRACTITIONER'S GUIDE TO THE TREATMENT OF THE OBESE PATIENT. By Edward H. Rynearson, M.D., and Clifford F. Gastineau, M.D. Charles C. Thomas Publishers, 301 E. Lawrence Ave., Springfield, Ill. $3.75.

PSYCHOSOMATIC GYNECOLOGY. By William Kroger, M.D., and S. Charles Freed, M.D. Free Press, 1005 W. Belmont St., Chicago, Ill. $8.

REDUCE AND STAY REDUCED. By Norman H. Jolliffe, M.D. Simon & Schuster, 630 Fifth Ave., New York 20, N.Y. $3.50.

TEXTBOOK OF ENDOCRINOLOGY. By Robert H. Williams, M.D. W.B. Saunders Co., 218 W. Washington Square, Philadelphia 5, Pa. $13.

THE IMPORTANCE OF OVERWEIGHT. By Hilde Bruch, M.D. W. W. Norton & Co., 101 Fifth Ave., New York 3, N. Y. $5.95.

WEIGHT CONTROL. By Ercel Eppright, PH.D. Iowa State College Press, Ames, Iowa. $3.95.

that good results are plain to see. And once the practice is started, it can build up rapidly.

How about fees? Almost all the interviewed men say they charge obesity patients at the going rate for equivalent attention. For the initial examination and prescribing, which may take sixty to ninety minutes, typical fees range from $25 up.

Until his desired weight is reached, the patient generally comes in for a weekly check-up. Medical men in the field say they usually charge $5 to $10 for such visits. Since the average co-operative patient loses about thirty pounds at the rate of two a week, he'll have fifteen check-ups.

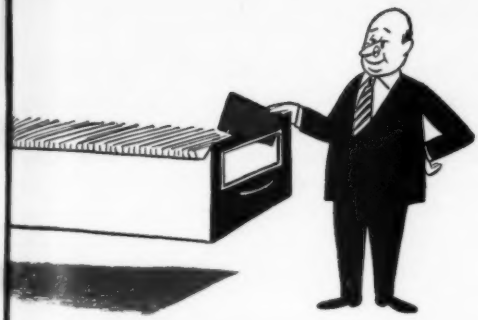
So the financial rewards of such practice aren't trifling, though many obesity patients do fail to stick it out for the full course. Some 40 per cent are likely to fall by the wayside, say most of the queried doctors.

Would you need special training in order to treat the overweight? Very little, according to most of the men. Says one internist: "A certified internist shouldn't need any extra training to break into the field. But I'd advise a few months' courses in metabolism and nutrition for the average G.P. Naturally, any doctor who wants to stay with it will keep informed by reading the literature and taking a one- or two-week refresher course every few years."

Several other weight-reduction subspecialists also recommend brief courses in basic psychiatry. And here's some advice from Dr. E. H. Rynearson of the Mayo Clinic: "Doctors should remember that obesity is usually not a disease, but a symptom of underlying tension. If they'd only take time to learn and understand their obese patients' problems, the patients would then accept advice on diet as part of a comprehensive program of therapy. And then, perhaps, more patients would stay with the medical profession instead of losing their money to cultists and quacks."

But Dr. Rynearson doesn't believe *formal* training is essential for the weight-reduction subspecialist. "The basic medical information is all in the books," he points out.

Twelve such books are listed in the accompanying box. If you want to do more than you're now doing for the overweight patient, think about adding some of them to your medical library. END



Practice-Building Secret: Set Up a 'Farley File'

Here's how one M.D. has built real friendship into his practice by jotting down reminders about patients' habits, tastes, and hobbies

By V. D. Hoffmaster Jr., M.D.

About a year ago, I heard the term "Farley File" for the first time. It was used in connection with a certain individual's habit of indexing names and stand-out characteristics of the people he met, so as to appear familiar with practically anybody on a second meeting.

The Farley File takes its name, of course, from James A. Farley, whose talent for remembering names and faces helped make him one of the most successful politicians of this century.

We doctors aren't politicians. But I've discovered in

THIS ARTICLE *has won one of the* 1957 MEDICAL ECONOMICS *Awards for its author, a general practitioner in Edinburg, Tex.*

my own practice that the Farley File technique can be enormously helpful in building good patient relations. In fact, I've used it for the past many years—without knowing it had a name.

Let me tell you how and why I evolved my system. The following paragraphs may give you some ideas for one of your own:

When I first started practice in a small Texas town, I was constantly struck by the fact that everyone seemed to know not merely my first name and that of my wife but also a lot about our hobbies and habits. At the same time, to my embarrassment, I couldn't even recall my patients' names, let alone whether they liked hunting, dogs, or fishing.

How I Started

So to help myself along, I began using a standard 8″ x 10″ card as a dual-purpose record. On one side of the card I'd note the date of the patient's call, the diagnosis, and pertinent facts about treatment. But during the call I'd take mental note of any purely personal comments the patient made. Then, as soon as he'd left the office, I'd jot down a few such things on the reverse side of the card.

Just before his next visit, I'd refresh my memory by glancing at the card. I'd note, for example, that he'd said he'd been badly sunburned while out fishing. So I'd make a point of asking him casually whether he'd done any more fishing lately.

It Made Friends for Me

The system worked like a charm. Two things happened almost immediately as a result. First, I found I was being invited more and more to go fishing and hunting with patients whose experiences in those fields I had recalled. Secondly, people began to treat me like a medical friend rather than an impersonal physician.

Today, my Farley File contains small memoranda and reminders that go back ten and fifteen years on many patients. And some of the notes have turned out to be helpful medically as well as socially. For example, I'll remind myself on the back of the card to ask the patient about that mole between his shoulder blades. Or I'll remember to ask him whether his ingrown toenail is still giving him trouble.

I've found that such comments can help prevent compli-

cations in otherwise innocent or benign conditions. What's more, they impress the patient with my interest in his whole body as well as his current ailment.

And with the passage of years, I've grown ever less dependent on the cards themselves. Through using them constantly, over and over again, I've actually trained my mind not to need them. I really know my patients by now. When I glance at a card, I often do it just to check my memory.

On my desk at this moment are four cards. As I turn them over at random, I find the following comments:

¶ "Allergic penicillin . . . Ask about trip to Chicago (1954) . . . Child thumb-sucker—ask if getting better (1956)."

¶ "Cheerleader in high school (1952) . . . Boy-friend dating another girl (1954)."

¶ "3 lb. 8 oz. trout (1950) . . . Taken fishing by him Sept. 2, 1950 . . . Hole in one, #7, 1951 . . . Tease about campfire-building ability."

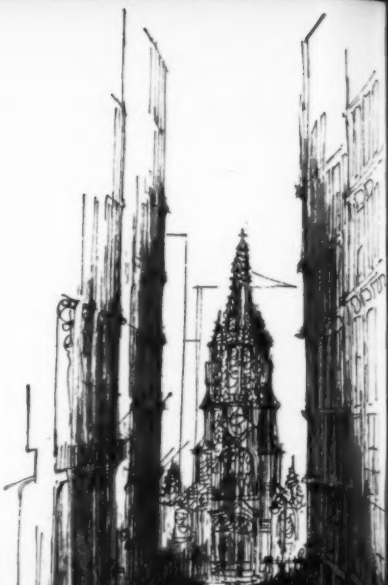
¶ "Son can't decide which college (1949) . . . Car wreck last night—minor scratches but car a total loss (1953) . . . Granddad is sure that grandson looks exactly like his side of family (1957)."

Those patients aren't merely patients to me. Even the ones I see only professionally are my friends. Try a Farley File yourself; I'm sure you'll soon discover that more friendly patients add up to a more rewarding practice. END

No Half Measures

I'd just started to practice pediatrics. One rainy midnight, the medical society's emergency service asked me to go on an urgent call. It took me half an hour over country roads to reach the patient. He was a young man in his twenties with a heavy respiratory infection.

After I'd treated him and was putting on my coat, his wife thanked me warmly for coming. "You know," she added, "there's a doctor who lives right next door to us, but I didn't want to call *him*. He's just a pediatrician."—M.D., MICHIGAN



What an Investment Club Offers You

Have unsettled business conditions caused you to shy away from stocks? Here's a good way to put your investment program on the right track

By Melvin J. Goldberg

In the back room of a suburban restaurant one night last month, thirteen men seated themselves around a table. Each threw $35 into the center. The problem at hand: how to make the money make more money. The discussion bounced around the room.

"I like the report we got on Phelps-Dodge."

"How many institutions own it?"

"Why don't we try the food industry this month? Sputnik or no, people will go on eating."

"I notice Safeway split."

"What's its price-earnings ratio and its upside-downside ratio?"

Professional investors? Not at all. Three of the group were physicians, eight were dentists, one was a musician, and one a field representative for an electric shaver company. This was the regular monthly meeting of the Passaic County (N.J.) Investment Club.

Dr. D. Vincent Varallo, president of the group, finally called for a vote. "We've heard Gene's report on the copper industry and Ed's report on foods. The question is whether we'll buy into one of them or buy more of an issue we already hold."

Slips of paper were passed around, and the members indicated the stock of their choice. The next morning a buy order was phoned in to the club's investment broker.

Throughout the nation, thousands of groups like the Passaic County Investment Club are pooling their capital and enthusiasm at similar meetings. An investment club, simply enough, is a group of people who get together to invest collectively. Although it can incorporate, few do. Usually such clubs operate as an informal joint venture, with just a brief set of operating rules.

If you've been thinking about investing more regularly

in common stocks, an investment club may be the way you'd like to do it. A number of physicians already have set up such clubs, either with their neighbors of with their professional colleagues. A doctor in Maine organized a club with his hunting friends, including among its members a lawyer, an accountant, and a lumberjack. The Sunday Investment Club in Lorain, Ohio, is composed exclusively of doctors—twenty-three of them.

Investment clubs were a comparative rarity until seven years ago. Since then they have boomed. The latest estimates place the number of clubs at more than 10,000. The amount of money they handle is staggering.

'Not a Gimmick'

"Far from being an investment gimmick," says New York Stock Exchange President Keith Funston, "clubs are putting stock ownership within the reach of many. By their size, soundness, and success, such clubs have earned a place in our arsenal of investment techniques—particularly for the apprentice investor."

Will you do better investing as a member of a club than investing on your own?

Not necessarily. Not if you've had investment experience, have the iron will to invest regularly, and have sufficient funds to diversify your holdings. For such doctors, an investment club ofofers no new profit potential.

Incentive to Save

But for most other doctors, membership in a club is a powerful inducement to regular investment of surplus savings. There are also good reasons for believing that investment decisions reached by the members jointly will generally be better than you could reach by yourself.

For example, you might be tempted to take a flier on the basis of a hunch or a tip. Convincing ten other people to go along with the same hunch or tip isn't easy.

Of course, ten men can be just as wrong in their decisions as you alone. But because club decisions are based on better information than most individuals have, the chances for success seem somewhat higher in the group.

They may not look that way

when the group first organizes. Many investment clubs shows little profit in their first year or two of operation. That's because of one-shot expenses, the higher commissions for small odd-lot purchases, and the club's own lack of investment experience.

Improves After a Year

After that, the club's batting average often picks up—sometimes spectacularly. One club formed in Detroit in 1941 has so far invested $30,542. Members now have a portfolio worth $94,121. And they've taken out more than $22,000 in profits.

Starting a club is even easier than finding one to join. All you need is a little money to invest and a few friends to go along with you. The National Association of Investment Clubs, headquartered in Detroit, will provide you with model bylaws, an accounting kit, and other aids. The New York Stock Exchange and many brokerage firms will assist you with information on how to open a club account.

Whether you want to start your own club or join an existing group, the following questions may well be in your mind. The answers, as I've given them below, will give you a good idea of how investment clubs operate.

1. *Who belongs?* The Stock Exchange recommends strongly that clubs be formed among people who already know each other and have some common interest. It's also important that all members have roughly the same amount of money to invest and the same investment aims. An all-doctor club would fit these requirements. But other types of members are desirable too.

For example, a lawyer is a good member to have. He can check the state and Federal statutes that apply to club operations. He can help out with any tax problems, too. An accountant will also come in handy.

Keep It Small

2. *How many members?* A club can have as many members as you want, but it's best to keep the group small. If you have too many members, you may find yourself in the investment company business. Then you'll have to register with the Federal Securities and Exchange Commission or with state authorities.

Most clubs range in size from ten to twenty [MORE ON 208]

What Labor Really Wants From You

This A.F.L.-C.I.O. spokesman says you should stop clinging to 'an outdated economic pattern'

Nelson H. Cruikshank is the chief health insurance expert for the A.F.L.-C.I.O. To sound him out on current labor attitudes toward private medicine, MEDICAL ECONOMICS' Lois R. Chevalier recently visited Mr. Cruikshank in the new $3,000,000 A.F.L.-C.I.O. building in Washington, D.C. Here's how he replied to a number of questions you yourself might well have asked:

Q. Last October, MEDICAL ECONOMICS published an article called "Is Labor Through With Private Medicine?" It reported the unions' increasing efforts to set up closed-panel plans that would "do away with all direct sickness costs" for U.S. workers. You've since charged, Mr. Cruikshank, that this report "compounded misunderstanding and prejudice." For the sake of the record, would you explain just what sort of health coverage the

A.F.L.-C.I.O. does want for its members? Or is there a national policy?

A. Remember, we're a federation. Each member union has to bargain for the best it can get. But in general, we believe a union should try for a direct-service health plan, such as the Kaiser plan in California. If it can't get such a plan, the second-best sort of program is service coverage with an income ceiling, such as Blue Shield offers. Last choice of all is an indemnity plan.

Q. Do you mean that labor no longer officially favors compulsory health insurance?

A. Let's put it this way: From 1942 on, we've favored national health insurance. Since it's been denied us by Congress, America's workers aren't standing on an abstract principle. They're more practical than some European labor groups, which refuse to negotiate agreements with their employers if they can't get exactly what they want. American labor is pragmatic. We're willing to settle for the next best thing.

Q. From labor's standpoint, then, is the issue of compulsory health insurance dead?

A. The tenor of Congress now is such that it would be a waste of effort to push for national health insurance. It's still our official policy. But I wouldn't predict we'll get it within the next ten years unless there's some major catastrophe, like a depression. And I wouldn't want the country to pay such a price for it.

Still, the country will eventually find that the multiplicity of private insurance schemes is burdensome and costly. For instance, Workmen's Compensation in most states is run with private insurance carriers. About 51 cents out of every premium dollar goes for benefits. The other 49 cents is absorbed in administrative costs, adver-

tising, agents with high expense accounts, and so forth. It's a terrible social waste.

By contrast, the Federal Social Security system runs on about a 2 per cent administrative cost. And it's the biggest insurance operation in the world. Federal health insurance would be a little more costly to administer, because evaluating medical claims is not as simple as determining age and death.

We're backing the Forand bill.* That will take care of older people's medical needs as part of their Social Security. If it proves successful, we'd like to extend it.

I know the A.M.A. says the Forand bill will be an opening wedge for national health insurance. We wouldn't deny it. But we have other objectives that are more immediate—and that we'll get sooner.

Q. What, for instance?

Labor's Next Goals

A. We have a bill in Congress that would give long-term, low-interest loans to nonprofit group-practice medical centers. Many unions would set up such centers on their own if they could get over that first hump of tremendous capital outlay. We'd prefer Government grants, but we'd take loans.

Q. Are you willing to have such centers limited to diagnostic work?

A. No. We'd like to see comprehensive-care centers, probably with Blue Cross for hospitalization.

Q. What about doctors to staff them?

A. In some places the medical societies have gone along with us. In other places, there's been stubborn opposition. In fact, I'd say there's a rising tide of reaction among doctors against this kind of plan. The spearhead of their attack is aimed at the United Mine Workers' program.

Q. Most doctors feel the United Mine Workers are spearheading an attack against *them*. It's a question of free choice of physician, isn't it?

A. The free choice thing is just semantics. If it means anything, it means that any organization has the right to choose its own doctors.

Incidentally, the medical profession has never supported our

*For a full account of the Forand bill, see "Front Man for Federal Health Insurance," MEDICAL ECONOMICS, Jan. 20, 1958.

drive for free choice in Workmen's Compensation. The A.M.A. has always gone along with the idea that the employer should select the doctor because he pays the bill. Isn't that attitude inconsistent with organized medicine's stand that the U.M.W. should *not* select its own doctors? Sounds to me like class loyalty.

Labor recognizes its great indebtedness to the A.M.A. I'm sure they'd be surprised to know how often we quote their standards. They've done a splendid job of exposing so-called healers like Hoxsey. MORE▶

"He's got one of those cardiac hearts."

Our basic quarrel with the individual doctor is that he refuses to recognize he's a *layman* in economics. He may be even worse than a layman; he may be an illiterate. That's partly because his intensive training in medicine deprives him of the broader education a lot of other people get.

Everyone respects scientists. So the things a doctor says are likely to be taken at face value. But in economics he's outside his field of competence.

Q. Doesn't the doctor have the same right as the union man to look out for his own interests?

A. That's what he thinks he's doing. He's come to believe his economic status depends on solo practice and on the fee-for-service system. That's a mistake.

'Labor Makes Mistakes'

Of course, sometimes labor also makes mistakes in its attempts to protect its economic interests.

Q. You mean featherbedding?

A. That's not a word I often use. But take a classic example: About the turn of the century, when Linotype machines were introduced, the old hand-typesetters went out on one of the longest strikes in history. They thought they were fighting for their economic interests. They couldn't believe the Linotype machine would mean an enormous expansion of the whole printing industry.

That's how it is with doctors who cling to an outdated economic pattern. They don't realize there could be an incredible expansion in health service if the problem of distribution could be solved.

Q. How could doctors help solve the problem of distribution?

Keep an Open Mind

A. First of all, they could face it with an open mind in the best tradition of their profession. They shouldn't pronounce a diagnosis without examining the patient. The A.M.A. isn't really doing itself credit as a professional organization when it goes into battle with mere slogans.

If there are elements of danger in the Forand bill, for instance, they aren't going to be disclosed by screaming "Socialized medicine!" The medical profession should make a reasonable analysis of the need. It should then suggest some alternative ways to meet it.

Take another recent example: Federal disability coverage under Social Security. The doctors could have said, "Look, we're against this. But if you insist on passing it, for heaven's sake at least do thus and so."

They didn't. So Congress was denied the constructive assistance of medical men.

Actually, the disability thing was a dramatic illustration of the two-level operation of the A.M.A. Politically, the doctors were opposed to the payment of disability benefits. They said such payments would destroy rehabilitation programs. Yet one of their councils got out a booklet on Workmen's Compensation that explained why disability benefits contribute to the injured workman's rehabilitation.

The A.M.A. booklet was inserted in full in the Congressional Record—at the request of the A.F.L.-C.I.O.

Q. You haven't told me what you think would be a sound position for doctors to take on the economic problems in their field.

A. I don't know. Every segment of society has to recognize a certain priority to protect its economic interests. We don't often see a great forward step taken by a group that's closely involved in a problem. Maybe it's asking too much of human beings to come up with the long-term view.

Unions have a responsibility to get the most they can for their members. They also have a public responsibility not to get it at the expense of others. But we all depend on the people on the other side of the table to remind us of our public responsibility. I expect it's true of both labor and medicine. END

Toss-up

Sign in the delivery room of our local hospital: "Mary had a little lamb . . . What'll *you* have?" —REGINA GIRARD, R.N.

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS *pays $25 to $40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J.*

Your Patients Want to Be Shown

There's a place in your practice for visual aids —whether scratch-pad sketches, plaster models, or illustrated recordings. Here's how doctors use them

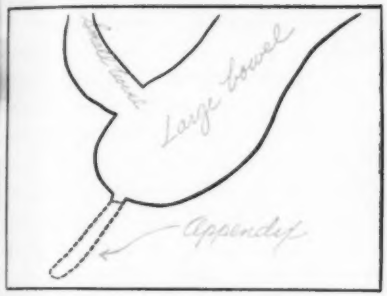
By John E. Eichenlaub, M.D.

Want to get your ideas across to patients more quickly and more certainly? The best way is to *show* them instead of trying to *tell* them.

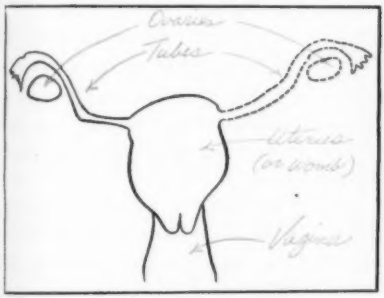
The typical patient soaks up the message from a picture or demonstration very freely—so freely that he often gains more from a crude diagram than from a polished lecture. What's more, he feels you and he are facing the situation *as a team* when you study a visual aid together. So it's a great boost to the doctor-patient relationship.

Some doctors use simple visual techniques without any special equipment or preparation. Others get materials from outside sources, often at little cost. Still others produce their own visual explanations and aids. Here are a few ideas about each of these three techniques—ideas you may want to consider for your own practice:

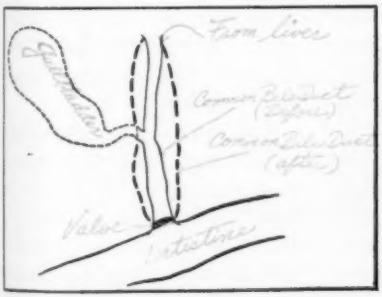
1. You can make your point with equipment already at hand. One topnotch visual aid is the ordinary scratch pad. "I always make a sketch when I propose an operation," says a gynecologist I know. "I simply draw a crude uterus, tubes, and ovaries. I circle what probably has to come out, and show what will still be left in good working



"As this sketch shows, Miss Jenkins, the appendix is a blind alley off the large bowel. *Your* appendix is infected. If we left it alone, the infection might burst out into the abdominal cavity and spread to your other organs. So we'll remove it. This will still leave a clear passage through the bowels. In fact, the appendix plays no part in digestion or elimination. So you'll never miss it."



"Here's a simplified sketch of your reproductive organs, Mrs. Wilson. We'll remove only one ovary and one tube. As you can see, I've drawn them with dotted lines. Your *other* ovary and tube will still be there to supply egg cells for future pregnancies—unless we find something wrong with them when we operate. The parts involved in marital relations won't be affected at all."



"As you know, Mr. Jones, the purpose of your gallbladder is to store bile, which the liver makes continuously. The bile is later released into your intestine to help digest food. You might think that after your gallbladder is removed you'll have to get along without storing up bile. But that's not the case. The bile duct itself will expand—as shown with dotted lines—and take over this function."

order. After surgery, I make sure that the patient and her husband get a sketch showing what was actually done. It's amazing how much it helps them understand the situation."

Avoids Bad Words

An internist makes another point: "Extemporaneous sketches help you past emotionally loaded words. So I fall back on pictures immediately when I want to discuss something like heart disease or stroke. I draw the blood vessels in the area, showing how one has become narrow or stopped up. By the time we get around to calling a spade a spade, I've had a chance to explain the patient's chances for recovery."

And he uses the same technique in recommending surgery: "I show them what's wrong and what can be done about it before even mentioning words like 'hospital' and 'operation.' For example, I sketch a gallbladder full of stones. I show how the bile will still pass through to the bowel without the gallbladder in place and how the bile ducts ultimately dilate and store bile. *Then* I broach the subject of surgery. With a workable answer to his trouble right before his eyes, it's easier for a patient to accept the somewhat frightening intermediate steps."

Some body parts or procedures are hard to clarify with a crude sketch. But even the simplest anatomic drawings in your textbooks may be too accurate for squeamish patients' comfort. A patient of mine once responded to Spalteholz's sketch of the viscera with a fainting spell. I haven't used my anatomy books for such a purpose since.

A better alternative seems to be an illustrated medical dictionary. My partner uses his as a combination resource book and filing cabinet for illustrative material. He clips art work, diagrams, and so on from pharmaceutical advertisements and folds them between the pages of the dictionary.

Why advertisements? Because commercial art, like dictionary art, is super-simple: lively and expressive without being repugnantly accurate.

A pediatrician in our town has another angle. When his youngsters outgrew "The World Book," he lugged it off to his office. "The pictures are wonderful!" he says. "And it's loaded

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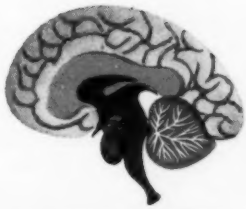

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with useful diagrams. Any physician with an old encyclopedia at home—particularly a juvenile one—might find it just the thing for office visual aids."

Idea for Radiologists

Radiologists, of course, have a vast advantage over the rest of us, since their efforts produce a constant stream of pictures. But one radiologist of my acquaintance recently came up with a notion that might prove useful to any doctor who explains X-rays: He compiled a desk-side file of normal films for ready comparison. A normal electrocardiogram, elucidated BMR tracing, glucose tolerance curve, etc. might serve comparably in your own field.

Then, too, the patient himself provides you with a handy visual aid. That's what Harvey Pearson uses. As a college-town G.P., he's bombarded with questions about everything he diagnoses, from dandruff to ingrown toenail. So he makes most of his explanations right in the examining room, while the patient is undressed. He keeps a hand mirror there. If there are any key findings the patient can't see in it, he sketches them on the patient's body with his finger or with an eyebrow pencil.

"You see the bulged-out veins down here," I once heard him say to a victim of varicose veins. "The real trouble is in the connections between the main leg veins underneath these muscles and the surface ones under the skin. When you walk"—and he moved the patient's ankle to demonstrate—"the muscles squeeze the veins underneath and push the blood up toward the heart. Valves right here keep the blood from flowing back again when the muscles relax. When the valves between the deep veins and these on the surface don't work, the blood just seesaws from one vein to the other in the leg, and these surface veins bulge out more and more."

"What can you do about it?" the patient asked.

Finger Surgery

"We'll make little cuts here and here." Dr. Pearson drew short lines with his finger. "Then we'll pass an instrument along the veins from one place to the other and remove them."

Less sophisticated patients might prefer a sketch. But most of Dr. Pearson's [MORE ON 220]

Your Stake in a National Blood Program

Here's why the doctor-backed Joint Blood Council hasn't lived up to advance billing—and what you and your colleagues can do about it

By Wallace Croatman

In January, 1956, President Eisenhower sent a congratulatory letter to the newly formed Joint Blood Council. "Our people," he wrote, "need a nation-wide blood service, coordinated not only to take care of national emergencies, but to make available to them in time of peace the blood and its derivatives necessary to save life . . ."

The letter gave the Presidential seal of approval to what seemed a very promising project. Many doctors as-

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THIS ARTICLE *is the third and last of a series on doctors' relations with community blood programs. For the first two articles, "What You Don't Know About Your Blood Bank" and "Why Blood Banking Is Still A Mess," see* MEDICAL ECONOMICS, *December, 1957, and Feb. 17, 1958.*

sumed at the time that medical men would at last be able to play a key role in blood banking.

Two of the Council's five founders—the A.M.A. and the American Society of Clinical Pathologists—were doctors' organizations.* Its president, its executive director, and several of its committee heads were physicians who had been strongly identified with the causes of private medicine.

So the Joint Blood Council was expected to become your best source of information about blood—for example, about new developments in blood fractionation or in blood-bank safety standards.

Purpose: Coordination

More important, it was hoped the Council would put an end to the irritating rivalries among competing blood-bank agencies. After all, its main purpose was coordination. And it was expected to become the central contractor for defense-blood agreements with the Government.

But in the two years of the Joint Blood Council's existence, most of those high hopes have been shattered. For one thing, in spite of the President's cordial letter, the Government simply hasn't played ball with the Council. Items:

Proof of Indifference

¶ When the Civil Defense Administration wanted some serum albumin for stockpiling, it called in the Red Cross.

¶ When the Government wanted a program for procuring whole blood in the event of an emergency, it again went to the Red Cross.

¶ The Office of Defense Mobilization recently reaffirmed a six-year-old directive that makes the Red Cross the official procurement agency for the National Blood Program.

Why isn't the Joint Blood Council doing the job it was set up to do? Dr. Frank E. Wilson, the Council's executive vice president, has pointed out that the organization's funds, staff, and powers are limited. "It's the goal of the Joint Blood Council to be a contracting agency for the national blood program," he says. "But it takes time to do that."

His patience isn't shared by

*Other charter members of the J.B.C.: the American National Red Cross, the American Association of Blood Banks, the American Hospital Association.

other interested physicians—among them, Dr. Oscar B. Hunter Jr., president of the American Association of Blood Banks. (The A.A.B.B., unlike the Red Cross, has no direct link with the Government. So it's especially eager for the Joint Blood Council to become the contracting agency for Government blood.) Says Dr. Hunter: "The J.B.C. and the A.A.B.B. are both going in the same direction. The only difference is that *we* want to get there."

The A.M.A. itself recently affirmed organized medicine's interest in seeing the Council "get there." Last June, its House of Delegates passed a resolution urging "immediate action to have the Joint Blood Council, Inc. designated as the contracting agency for blood procurement with all governmental agencies." MORE▶

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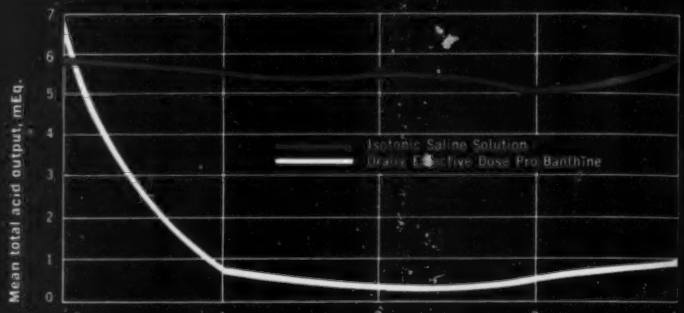

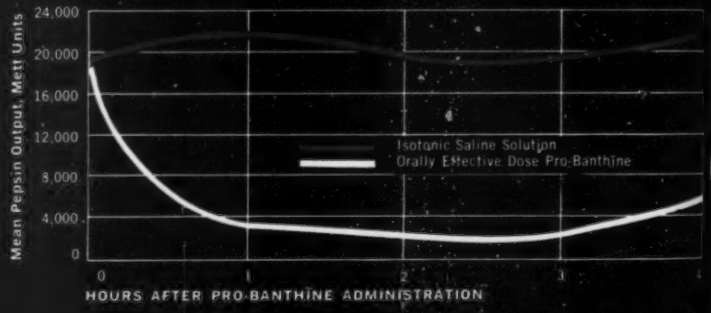

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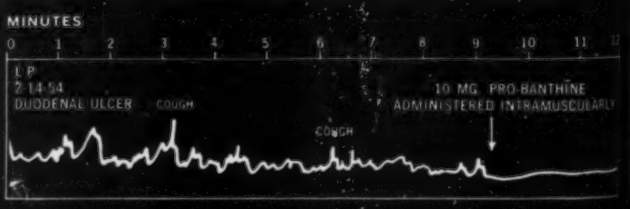

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1. Barowsky, H., in discussion of Barowsky, H.; Schwartz, S. A., and Lister, J.: Experience with Short-Term Intensive Anticholinergic Therapy of Peptic Ulcer, Am. J. Gastroenterol. *27*:156 (Feb.) 1957.
2. Sun, D. C. H., and Shay, H.: Optimal Effective Dose of Anticholinergic Drug in Peptic Ulcer Therapy, Arch. Int. Med. *97*:442 (April) 1956.
3. Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthīne in the Treatment of Peptic Ulcer, Am. J. M. Sc. *232*:156 (Aug.) 1956.

SEARLE

What immediate action? Ah, there's the rub. So far, there's been no authoritative definition of what should be done to invigorate the lagging J.B.C.

Last December, in fact, the Council's Board of Directors decided that, for the foreseeable future, the J.B.C. will *not* be able to carry out its purpose of serving as broker between the Government and civilian procurement centers.

One thing seems clear: The Council needs more support from *you* if it's to get on with its job. It needs moral support. And it needs financial support.

Consider your stake in the national blood program:

What It Means to You

The question of where defense blood comes from concerns all doctors. Defense-blood collections offer real advantages to participating blood banks. They're advantages that should make it possible for you to give increasingly better service to your patients.

Let's assume that your community blood bank is taking part in current efforts to get serum albumin for civil-defense stockpiling. Since the Government pays only the audited cost of the blood it gets, your bank won't make a direct profit on the deal. But it will profit indirectly in the following manner:

An Outlet for Plasma

Present regulations allow blood centers to make shipments in the form of plasma, which your bank probably has lots of. So the defense project can serve your bank as a convenient outlet for plasma made from outdated blood, rejects, and the like. Money from the Government can then help defray costs of the center's regular operations.

For practical reasons, then, non-Red Cross banks *want* to collect for defense through the Joint Blood Council—not as subcontractors to the Red Cross. The fact that the Government went directly to the Red Cross when it wanted serum albumin in 1956 was bitterly resented by the doctors who run many independent blood banks. And the story of what happened next makes a good object lesson. Here, briefly, are the facts:

In October, 1956, Dr. Sam T. Gibson, director of the Red Cross blood program, announced that the Red Cross

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planned to collect some 330,000 units of blood for civilian defense. And he invited A.A.B.B. banks to take part in the operation *as subcontractors to the Red Cross.*

This was the first official word of the project. Non-Red Cross blood centers moved into frenzied action. Some fifty banks began negotiating with the Red Cross over quotas, prices, and similar matters. But formal agreements couldn't be made until the Red Cross had signed its own contract with the Government.

As a result, subcontracts didn't reach the A.A.B.B. banks until the following February. Moreover, the contracts called for whole, fresh blood.

"Why won't plasma do just as well?" demanded community banks from Miami to Seattle. Dr. Gibson's reply was that the Government set the requirements, not the Red Cross. (Later, the whole-blood requirement was changed—as a result of Red Cross insistence, according to Dr. Gibson.)

Only nineteen non-Red Cross banks finally signed up. And as

a partial result of all the delay, confusion, and ruffled feelings, they've so far been unable to meet their obligations. Though the original A.A.B.B. quota of 100,000 units of blood has been scaled down, the member banks were able to provide less than two-fifths of the quota by the beginning of 1958. Meanwhile, Red Cross regional centers have been delivering at about 90 per cent.

What does the story prove? Well, as the Red Cross sees it, it indicates that non-Red Cross community centers can't be relied on. Says one Red Cross official: "I doubt if the Joint Blood Council would have had any more luck dealing with those banks than we've had."

Another Point of View

But from the standpoint of community blood-bank leaders in Milwaukee, Denver, San Francisco, and other cities, the experience proves something very different: It shows that the Red Cross isn't at all sorry when other blood-procurement agencies look inefficient.

To the outsider, the whole

fiasco simply underscores the need for doctors—collectively and individually—to take a more active interest in blood procurement. Which brings us back to the Joint Blood Council:

The Council naturally knew about the serum-albumin dispute. It even set up a committee to investigate the whole subject of defense-blood requirements. The committee has since recommended closer liaison between the J.B.C. and the various Governmental agencies concerned with blood.

But what good are recommendations without the necessary financial resources and the necessary authority for the Joint Blood Council to play a forceful role?

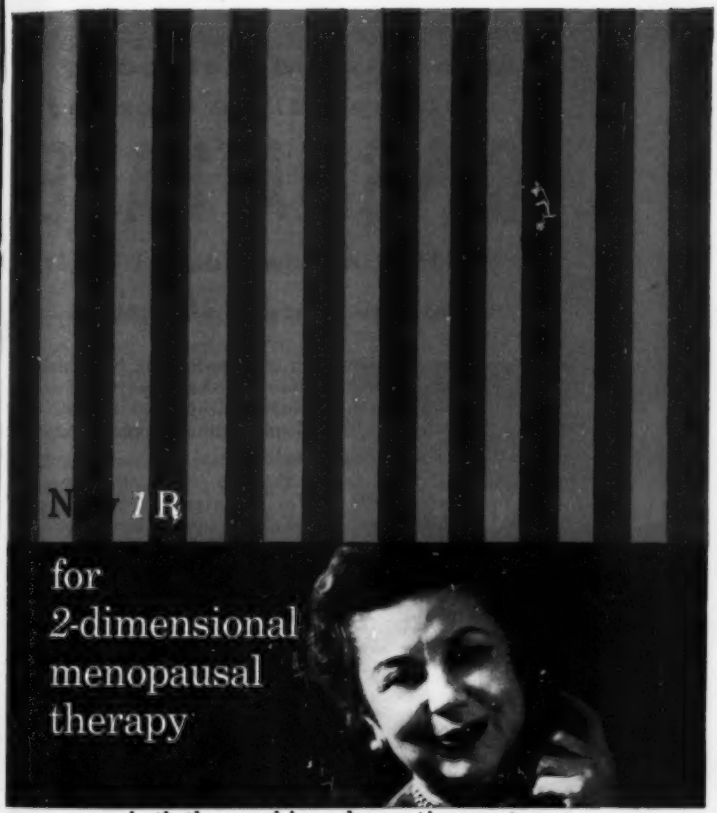
To be sure, its record to date isn't devoid of accomplishments.

What It Has Done

Among other things:

¶ It has published a pamphlet, "Standards for Accreditation of a Blood Transfusion Service," that promises to raise the standards of blood banks willing to abide by Council criteria.

¶ It has conducted a survey



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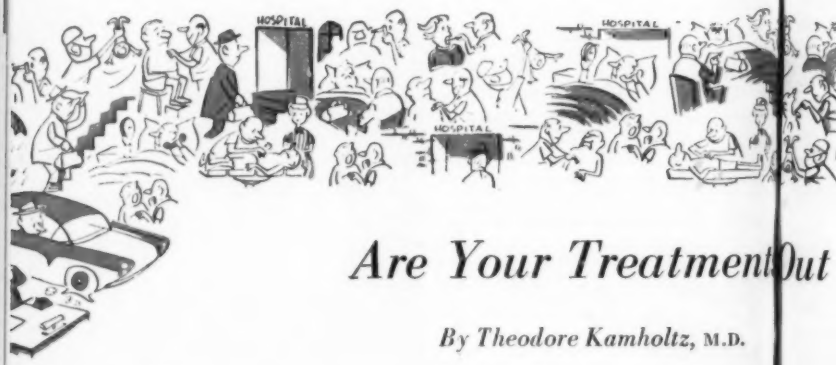
whose results indicate that U. S. doctors are ordering about 4,500,000 transfusions a year. The study reveals that about 38 per cent of the blood comes from the Red Cross; the rest is drawn from hospital, community, commercial, and other sources.

¶ It's working on a survey of blood-banking practices that should give you the best yardstick yet for judging whether or not your local blood program is well run.

¶ It's trying to persuade commercial insurance companies not to include the cost of blood as a benefit in health insurance contracts. (Patients with such in-

surance have no financial incentive to replace blood. So the effect may be to dry up a community's blood supply.)

All of these activities are creditable. But the J.B.C.'s major job of coordination at the top just isn't being done. It probably couldn't be done under the present set-up. Currently the Council is practically a one-man operation, with a total budget of less than $50,000 a year. (The A.M.A. and the Red Cross each contribute $20,000; contributions from the other Council



Are Your Treatments Out

By Theodore Kamholtz, M.D.

A generation ago, your grandfather gave his patients a medicine that really tasted like medicine. Today, you give *your* patients delicious doses of ambrosia. Tomorrow, your grandson may be prescribing something awful again. That's the way it goes in this profession.

There are fashions and fads in everything, and we doctors aren't immune to them. They tend to run in cycles. What was good yesterday is apt to seem terrible today and to turn good again tomorrow.

Suppose, for instance, you favor early mobilization after sur-

members are, for the most part, negligible.)

What's needed? From organized medicine: more money, more publicity, more active backing of the J.B.C. From you as an individual: more insistence that your local blood program (whether A.A.B.B., Red Cross, or independent) regard its activities as part of an over-all *medical* effort.

That's what it will take, in the opinion of the best-informed observers, to clear up the blood-bank mess END

ent Out of Style?

gery. Your opinion is current. You're a modernist. If, on the other hand, you don't believe in it, you're behind the times.

Let's say you have dark suspicions about booting a patient out of bed before sutures are tried and true. You believe in rest—tying a patient to the bed, if necessary. When you voice these ideas, you may be called an antiquarian. But don't fret. Ten or twenty years from now, your belief will prevail again, and you'll be vindicated.

At the same time, the true-blue mobilizer is on equally solid ground. If he lives for another

thirty or forty years, he'll probably live through the expected reaction to his point of view. And early mobilization will once more be the rage.

Now, who is the more modern? It can reasonably be expected that the pendulum of early vs. late ambulation will swing violently for a number of years until some future authority decides that it really doesn't make any difference. By that time, the question will have been resolved by eliminating the need for surgery entirely.

So if you find it hard to decide where your own particular fancies or convictions belong in the scheme of things, don't worry. There are several ways of facing up to the problem:

What to Do About It

Easiest of all is just to go on practicing the brand of medicine you learned at school. This leaves you synchronous with your class—*and* with the classes of forty and eighty years hence. True, you're sadly out of phase with the twenty- and sixty-year-hence classes. But just hold to your faiths, and time will justify them.

Or, instead, why not develop a profound and undeviating skepticism? Take the common cold, for instance. First your credo: "I believe the common cold will never be cured. I believe it will disappear in two weeks without treatment and in a fortnight with approved medical therapy."

How Skepticism Helps

This puts you in a fantastically good position. Every three months, when a cure for the cold appears in the literature, you can laugh heartily. You can state with conviction that this treatment will run its appointed course and be forgotten. What's more, you'll be right. So you'll gain the reputation of rare good judgment.

One day, when you're looking the other way, maybe a cure for the cold *will* be discovered. But nobody will remember your righteous conservatism amidst the jubilation and carnivals.

If It's Fun, It's Good

The newest and best way of riding out the cycle is to join the hedonistic or pleasure-loving school. Its basic tenet may be paraphrased to read, "The medicine doesn't have to be nauseat-

ing to be effective." This has a natural corollary that goes, "If the medicine *is* nauseating, it's probably not effective."

In childhood, for example, you hated spinach. When you became a doctor, you scoured the literature for an article proving spinach harmful to health. If you didn't find it, you wrote one.

And why not? There's a great deal to be said for the hedonistic

Thanks for Matilda

As a senior medical student, I was putting in my stint at the county hospital's receiving room. I'd finished what I thought was my last case of the day when a small, tearful boy arrived clutching a squalling cat. "Can you fix Matilda, Doc?" he implored. "A car hit her just now."

No other patients were waiting. So I got the floor interne and the resident. "Say, where is a cat's tibia?" said the resident, pinching the animal's femur. The cat responded with a bloody yowl, and we decided we'd better do something quickly. The three of us strapped the cat to the operating table, set the broken bone, sutured the skin, and prepared a splint of tongue blades.

Our operation completed, the boy thanked us profusely. "Matilda and I will never forget this," he told us. And we soon found out how much he meant it:

Two days later, when I was again on receiving room duty, three small boys showed up and beckoned me aside. They had two mangy-looking dogs with them. "We hear you fix animals, Doc," the dirty-faced spokesman announced. "The gang's bringing some more around this afternoon. Now Butch, here . . ."

For weeks afterward the hospital receiving room resembled a dog and cat clinic. —ALLEN W. DAHL, M.D.

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"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. 8:1075 (July) 1957.

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How the revolutionary new Absorption Enhancement Factor was discovered

While conducting a long-range study of Vitamin B_{12} serum levels in several groups of patients, Chow of The Johns Hopkins University found that one group consistently showed surprisingly high B_{12} levels. Investigation revealed that these patients were receiving an experimental oral vitamin preparation made by Smith Kline & French.

After many months of investigation, the factor responsible for the enhanced B_{12} absorption was identified. It was found to be D-Sorbitol—an agent that had been included in the formulation as a sweetener and pharmaceutical stabilizer.

Further investigation brought forth a discovery of equal, or perhaps even greater, significance: this **Absorption Enhancement Factor** produced its effect not only on B_{12}, but also on iron.

Smith Kline & French Laboratories,
Philadelphia

school. Someone had to dislike bloodletting, cauterizing wounds and purgatives before medicine could rid itself of them.

The progress of medicine is full of vindication for the physician who likes to pamper himself and his patients. He knows what's pleasant and what's not. Sooner or later, whatever his course is, it's bound to prevail.

If he likes keeping out of trim, reading in negligible illumination, or sleeping in supersoft beds, he can feel assured that eventually his point of view will be looked upon as the right one.

If he likes daily baths, they'll be sanctioned. If he prefers monthly baths, someone is bound to prove daily ones too caustic.

Why Not Just Guess?

Closely allied to the hedonistic is the intuitive school. It's easy to subscribe to this philosophy, but it takes a determined M.D. to carry it off.

Let's say you suddenly decide that disease is all a matter of water imbalance (allergy, atmospheric pressure, or miasma will do as well). In this blinding revelation—entirely free from the constraint of cold reason—you see clearly the universality of water and the disorders of hydration that make for asthma, botulism, croup, and so on. It's easy enough to build up the rationale of this theory.

By painstaking adjustments of water balance, you weave your theory and practice together. Then you write—voluminously, of course. Your colleagues begin by saying you're crazy. Then, gradually, they come around. One day you're sure to find yourself an authority on water balance. The only danger is that the acknowledgment may come posthumously.

Let's not deride the intuitivists. Medicine owes a tremendous amount to eccentrics who wore a hobbyhorse ragged. So if you've just discovered that horse dander is The Cure for The Disease (without, of course, having thought much about it or tested it), don't be bashful. Tell the world about it. Call in the press, and make a statement.

Can You Take It?

This should start the desired chain reaction. In a few months you will be investigated and denounced as a fraud. You will be vilified in a scholarly article called "Distilled Horse Dander

Does Not Cure The Disease." You will then write back an indignant letter saying you never claimed horse dander cures The Disease; it only ameliorates it.

After an appropriate interval, the next article appears: "Horse Dander Does Not Ameliorate The Disease." You write another indignant letter to the editor, complaining that the techniques you used weren't followed.

Properly managed, this controversy can be dragged on for years. Meanwhile, you've become known as The Doctor for The Disease. You are now in a position to state that unfortunately—due to increased costs—it will hereafter be necessary to raise your fees.

The Hard Way

For most of us, though, keeping abreast of medicine is just hard, plodding, and sometimes jolting work. We learn, unlearn, and relearn. We read, attend courses, and hope that some of the stuff we study today will still seem worth knowing tomorrow.

At least we're sure to be up-to-date sometime, if we can only hold out long enough. END

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Easy Way to Get Full Financial Records

A simple, inexpensive peg board can reduce most of your bookkeeping to one easy step

By Hugh C. Sherwood

Does your bookkeeping system take up too much of your aide's time? Does it delay the sending out of your bills and thus diminish your chances of collecting? If so, it will pay you to look into some of the speedier accounting systems now available to doctors.

One such system is built around an automatic accounting machine.* But perhaps you don't want to spend the amount of money any such machine costs (about $1,500 for a typical one).

There *is* a cheaper answer to the problem. A number of doctors now use a so-called peg-board system of accounting. In addition to its comparatively low cost, it's easy to get used to. And it can reduce the main part of your aide's bookkeeping chores to one simple step.

How? By permitting her to fill in several forms at the same time. Among them: an individual account card, a monthly statement, a cash receipt form, *and* a daily journal sheet showing all procedures, charges, and cash payments for that date.

As its name implies, a peg board is simply a flat board with pegs (or clamps) along one or both sides. The pegs

*See "This Bookkeeper Pays *You*," MEDICAL ECONOMICS, Mar. 3, 1958.

hold perforated forms in alignment while the aide fills them in.

At the start of each day, she attaches the daily journal sheet to the board. Then, as she sees a patient, she places his individual account card and monthly statement in carefully aligned positions over the day sheet. If the patient pays cash as he leaves, she puts a receipt form on top of the other three. By means of carbon paper or carbonized forms, she can record information on all the forms in one writing.

Doctors who've installed the peg-board system in their offices say it has the following advantages:

¶ It saves time—particularly at billing periods. Since the board enables the secretary to fill in three or four form as patients leave the office—or to do a whole

batch in a few minutes at the end of the day*—she needn't spend long hours transferring figures from daily journal to individual account cards to monthly statements. As a Newark, N.J., pediatrician explains it: "On the first of the month, my aide merely puts the statements in envelopes and mails them out. It's much faster and less fuss than our old system."

Tell Them Why

¶ It provides patients with itemized bills. Says an Iowa doctor: "It's surprising how often my patients used to forget some important part of their treatment. And the less they remembered, the higher the charge looked to them. Now, because our peg-board forms have spaces for indicating procedures, I get far fewer complaints than I used to."

No Fumbling Fingers

¶ It cuts down errors. Bookkeeping mistakes often occur while the aide transfers figures from her day sheet to an account card—or from the card to a monthly statement. Since peg boards make it possible to fill in all forms at once, such copying errors are not a hazard.

¶ It's extremely uncomplicated. Although at least one manufacturer allows two hours for teaching secretaries how to use the peg board, most doctors agree the system can be learned much more quickly. Says a San Francisco professional management man: "Nurses or office assistants can be trained to run peg boards in a few minutes." Since it's so easy to learn, almost anyone could fill in for your aide in a pinch.

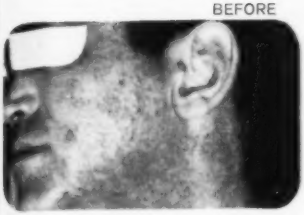
What They Cost

Peg boards range in price from around $5 to $275: A typical one costs about $35. A few months' supply of forms, plus trays to house individual account cards and other equipment, will set you back another $75 to $300. This latter amount isn't much more than you'd pay for the extras required by any ordinary bookkeeping system.

Who makes the bookkeeping equipment? Here are some of the better known manufacturers and their home offices: C. R. Hadley, Los Angeles; Norfield Methods

*If your aide is often too busy to fill out forms as patients leave your office, you can employ duplicate cash-and-charge slips that list the procedures you perform. From these, she can fill out account cards, statements, and the day sheet after office hours.

BEFORE AFTER



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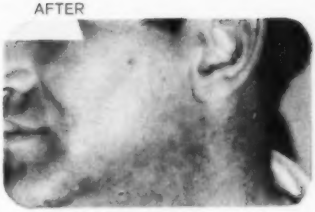

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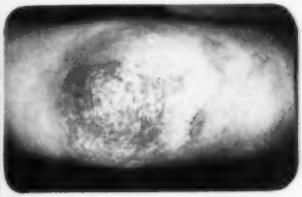

acute contact eczema

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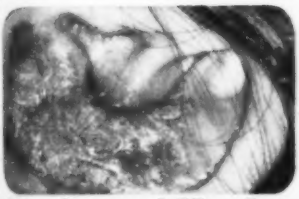
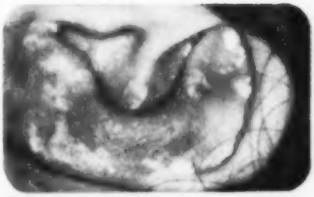


infectious eczematoid dermatitis



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Board or Machine?

In view of the peg board's advantages, would a change from your present bookkeeping system be worth-while? If you have a very limited practice, it probably wouldn't. But if you send out hundreds of bills a month, you might well consider installing either a peg-board or an automatic accounting machine.

Which should it be? Naturally, the answer depends mostly on the size of your practice and your pocketbook. The machine does a number of things the board can't. For example:

It handles arithmetical calculations automatically—thus minimizing the chance of mistakes even further than does the peg board. It produces neat, machine-printed statements. And once the secretary learns how to use it, it does the bookkeeping job far more rapidly than could any manual system.

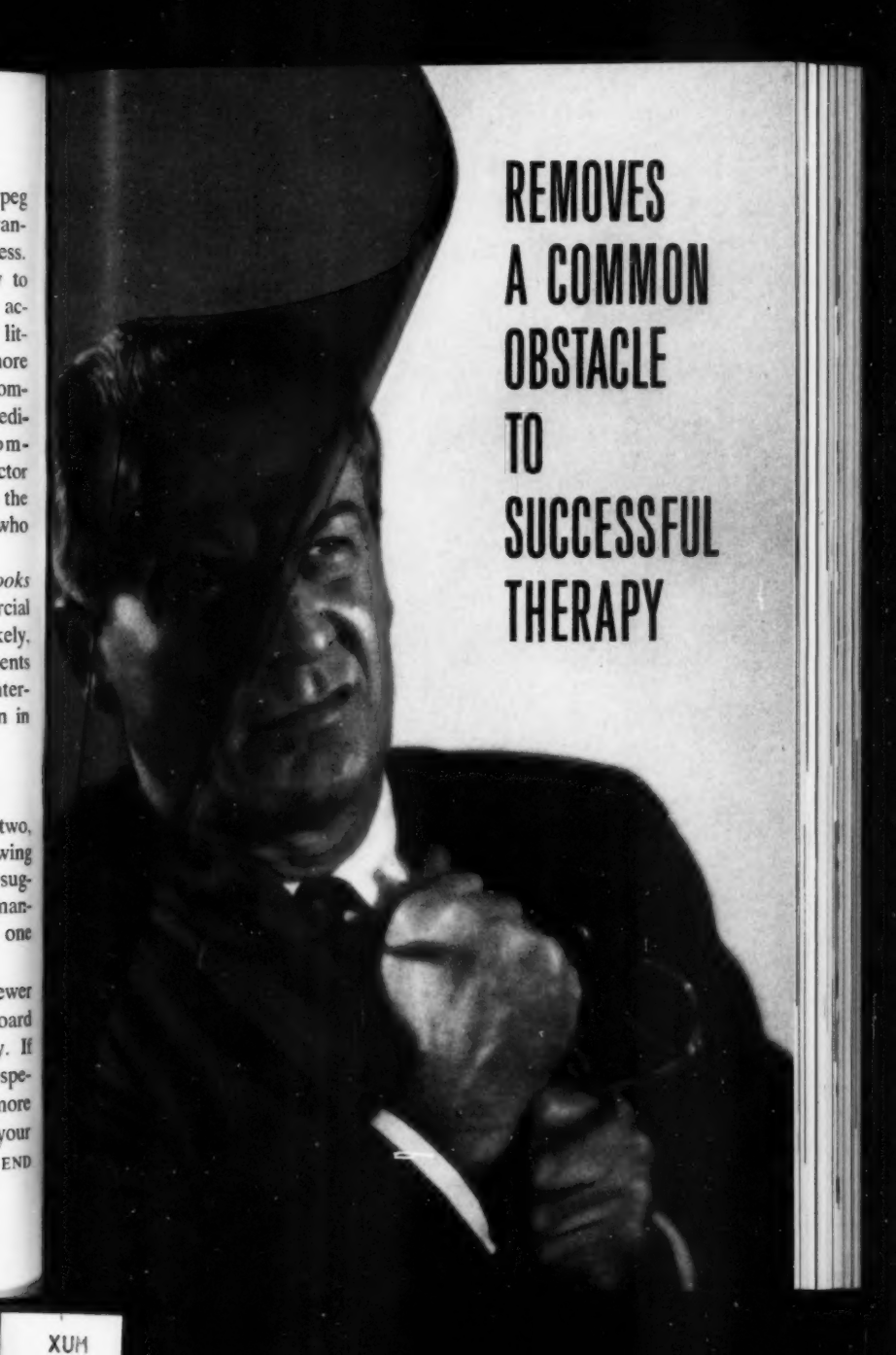
On the other hand, the peg board has two distinct advantages apart from its cheapness. First, as I've said, it's easy to operate. (The automatic accounting machine requires a little more training and a few more weeks to feel completely comfortable with. So, as one medical management man comments, "it may leave the doctor at the mercy of an aide who's the only person in his office who knows how to work it.")

Secondly, the peg board *looks* much less slickly commercial than the machine. It's less likely, in other words, to give patients the idea that you're more interested in making money than in caring for them.

A Good Rule of Thumb

In choosing between the two, you might consider the following rule of thumb. It has been suggested by some professional management men and at least one manufacturer:

If your billings come to fewer than 500 a month, a peg board is probably the better buy. If they're more than that—especially if they're a great deal more—a machine is likely to be your best bet. END


REMOVES
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OBSTACLE
TO
SUCCESSFUL
THERAPY

Compilation of data from an extensive clinical evaluation, which included 4,860 patients, reveals that anxiety and tension are quickly allayed with 'Ultran.'[1] Results further show that 'Ultran' is most beneficial in certain conditions. Those that respond best are as follows:

Diagnostic or Descriptive Category	Number of Patients Treated	Percentage of Patients Improved
Premenstrual tension	77	86
Insomnia or somnambulism	49	82
Neurasthenia and neurocirculatory asthenia	105	75
Emotional instability	55	75
Menopause	475	74
Anxiety states	2,719	72
Pain (adjunct)	48	71
Psychosomatic illnesses*	380	71
Alcoholism	109	71
Tension headache	116	69
Migraine headache	46	63
Hysteria	68	63
Psychoneurosis (type unspecified)	238	62

*Include asthma, hay fever, dermatoses, gastro-intestinal complaints, etc.

In a study on hypertension, 'Ultran' was shown valuable in relieving anxiety and tension.[2] In geriatric patients, 'Ultran' has been observed to be helpful in calming 82 percent of moderately agitated and 61 percent of severely agitated senile cases.[3]

Pulvules of 300 mg.; usually 1 t.i.d.

1. Summary of extended clinical trial data, Lilly Laboratory for Clinical Research.
2. Rhode Island M. J., *40*:514, 1957.
3. Geriatrics, *12*:607, 1957.

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Answers To Your Tax Questions

With April 15 coming on, it will pay you to study the replies to these typical Federal income tax queries posed by other physicians

By Joseph F. McElligott

Among the many income tax questions my clients have been asking me, the following seem worth passing along to doctors in general. In each case, I'll state the question as it was asked. Then I'll follow it with an answer that I've had checked by the Internal Revenue Service:

Q. *I have an insurance policy that pays off in case I'm unable to work. May I deduct the premiums as a business expense?*

A. There's an important distinction to be made here. If the policy you have is an overhead-expense policy (which pays your actual office expenses while you're disabled), the premium is deductible. But any payments made to you under the policy are reportable as income.

On the other hand, if yours is a standard health-and-accident policy (which pays you a fixed monthly income

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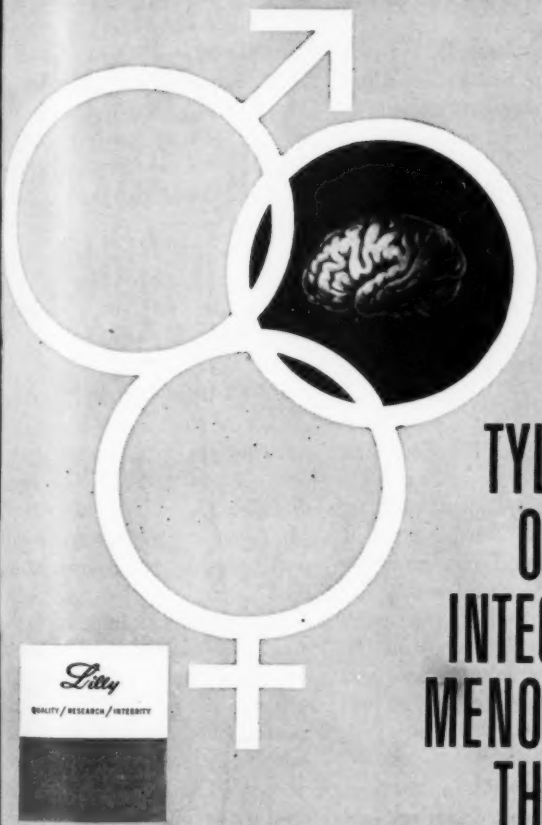
THE AUTHOR *is a New York City tax and medical management consultant who formerly worked for the Government as an Internal Revenue agent.*



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while you're disabled), the premium is *not* deductible. Conversely, the payments you get under the policy are *not* taxable.

Selling a Lease

Q. *Last year, the obstetrician in the next office to mine needed more room. So he bought out my lease for $1,000, and I moved elsewhere. Do I report this profit as ordinary income or as capital gain?*

A. It's a capital gain. And if you had the lease for more than six months before selling, it's a long-term capital gain, taxed at a lower rate. Furthermore, if you left behind any improvements (partitions, carpeting, fixtures, etc.) on which you hadn't recovered the entire cost by depreciation or amortization, you can deduct the unrecovered portion on this year's return.

Late Filing

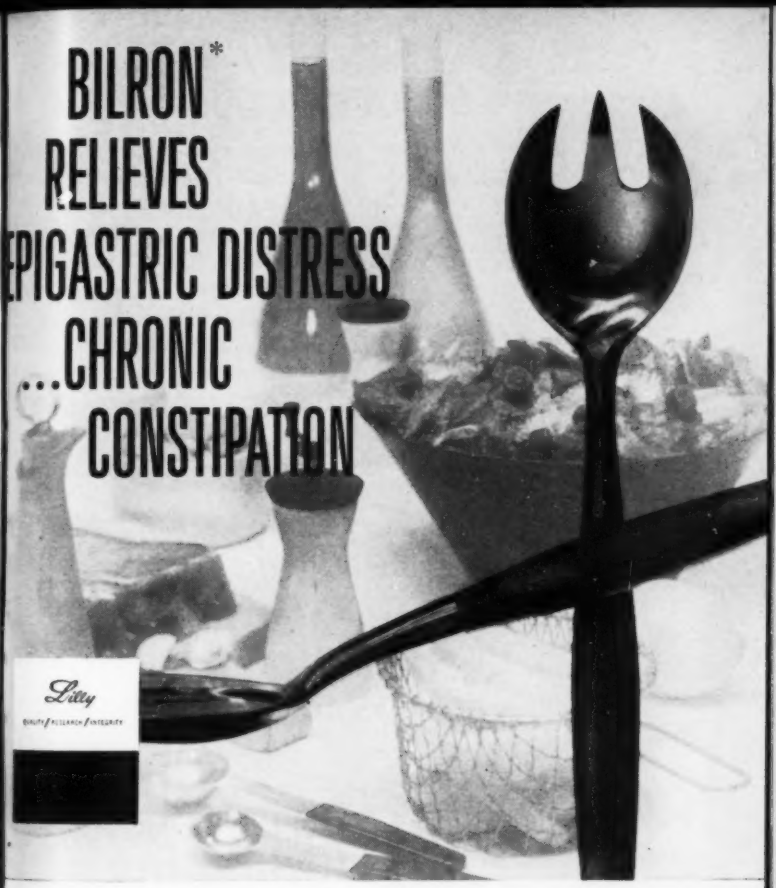
Q. *I've heard I can get permission to postpone filing my return if I don't have the money to pay the tax due on April 15. Is this true?*

A. No, you have two points confused. Even if you can't pay the tax due, you must file a return by April 15. When you file, you can also fill out a Form 1127, requesting more time in which to pay. But if you aren't able to file your return by April 15, for some good reason *other* than inability to pay the tax due, you can request permission to file later. (For example, you might need more time to assemble the facts on a complicated business deal.)

Gift or Income?

Q. *I'd like to make a substantial cash gift to a former secretary whose husband has been disabled for six months. How can I give her the money so she won't have to pay income taxes on it?*

A. It's almost impossible to give money to a former employe in such a way that the Treasury will regard it as a gift rather than as taxable "compensation for past services." So why not simply increase the check you send by an amount large enough to cover the tax she'll have to pay? If you want to give her, say, $1,000, raise it to $1,200. She then pays $200 in taxes and ends up with what you intended her to have. And there's a big advantage to you in this approach: By treating the $1,200



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as compensation for past services, you can deduct the entire amount as a business expense. But if you treat it as an outright gift, you can't deduct a penny of it.

State Tax Returns

Q. *Is it true that the Federal tax men are allowed to inspect state income tax returns (and vice versa) in order to compare income figures, deductions, etc.?*

A. Yes, in an increasing number of states. It's been found that some taxpayers who fail to report items of income on their Federal return will include them on state returns, where tax rates are lower. Make sure there

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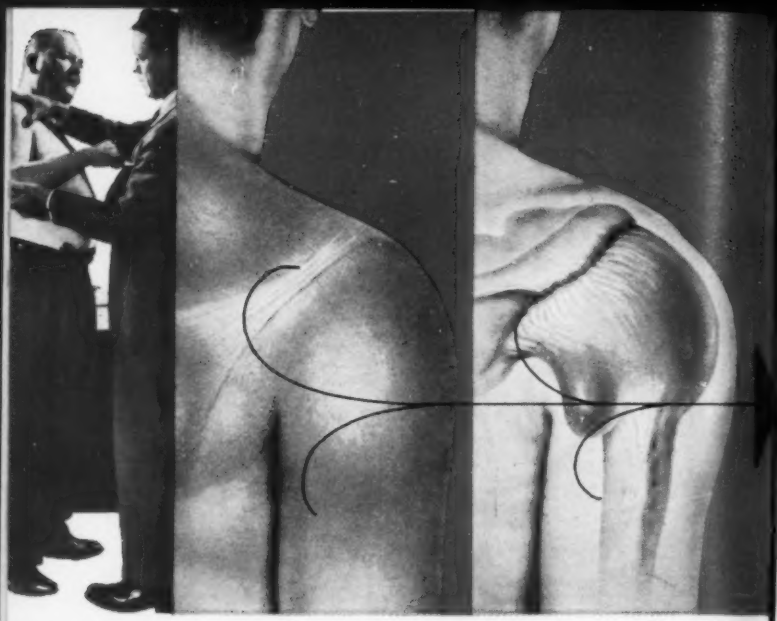
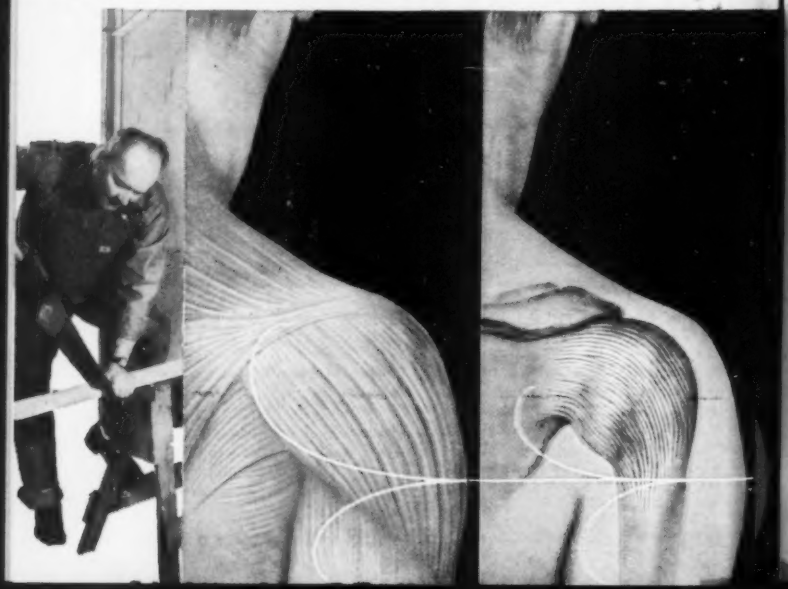


Rheumatoid arthritis is a constitutional disease with symptoms affecting chiefly joints and muscles."[1] "Pain the affected joint is accompanied by splinting of the adjacent muscles, with resultant 'muscle spasm.'"[2]



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1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953). 2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

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TAX QUESTIONS

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Deductible Loss?

Q. *Years ago, my wife's mother invested a sizable amount in jewelry. She felt it would be a better hedge against inflation than an investment in stocks. Also, she liked the idea of using and enjoying the jewels before cashing in on her profits. But last year, when she sold some pieces to provide college funds for a grandchild, she took a loss of $1,200. Can she deduct this as a capital loss?* MORE▶

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Niacinamide	10 mg.
Riboflavin (B_2)	2 mg.
Vitamin B_{12}	2 mcgm.
Ascorbic Acid (C)	50 mg.
Vitamin K (Menadione)	0.5 mg.
Folic Acid	1 mg.
Ferrous Fumarate	90 mg.
Iron (as Fumarate)	30 mg.
Intrinsic Factor	5 mg.
Fluorine (as CaF_2)	0.015 mg.
Copper (as CuO)	0.15 mg.
Iodine (as KI)	0.01 mg.
Potassium (as K_2SO_4)	0.835 mg.
Manganese (as MnO_2)	0.05 mg.
Magnesium (as MgO)	0.15 mg.
Molybdenum (as $Na_2MoO_4 \cdot 2H_2O$)	0.025 mg.
Calcium Carbonate	575 mg.
Zinc (as ZnO)	0.085 mg.

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A. The general rule is this: You can deduct losses on the sale of capital goods but not on the sale of personal goods. Thus, your mother-in-law could deduct her loss only if she could prove her real purpose in acquiring the jewelry was that she wanted to make a profit on it. Since she has apparently been wearing and enjoying it for years, she'd probably have trouble convincing a T-man of her right to deduct the loss.

Special Tax Form

Q. *In 1957, a substitute doctor covered for me while I took a much-needed six-week vacation. On a percentage-of-fees basis, I paid him $1,500. Now, in making out my return, I see I didn't withhold taxes on this amount. Should I have done so?*

A. No. Taxes must be withheld only on regular salaries. But you should have filed a Form 1099 before Feb. 28, 1958. The law requires you to file such a form for anyone to whom you've paid $600 or more in any one year.

Future Trouble?

Q. *On last year's return, a medical expense deduction I'd taken was disallowed. Since I had simply misread the rules, the agent and I settled the whole thing amicably. Now another doctor tells me that as a result of the error my name will be on a special list, and my return will be audited every year. Is this standard Revenue Service procedure?*

A. Though tax agents aren't instructed to keep a list of suspected returns, many of them probably do.

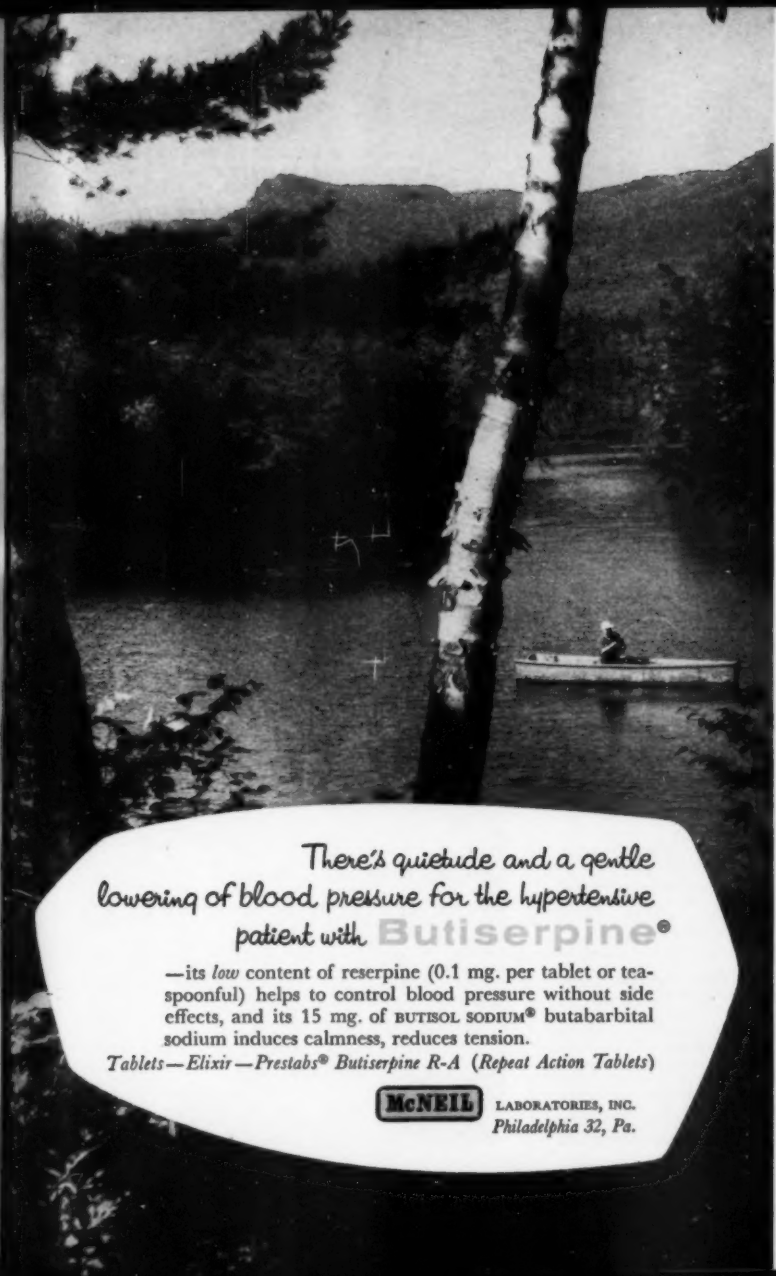
But I wouldn't worry too much about being a special case. Your return may be automatically audited anyway. (See the answer to the next question, below.)

Audit Selections

Q. *Is a tax return automatically selected for audit just because it comes from a physician?*

A. Not exactly, though it sometimes seems so. This much is true, however:

If your adjusted gross income (professional net plus other earnings) is over $25,000, your return *will* be set aside for audit. And if your adjusted gross is over $15,000, the return will automatically be placed in the "possible audit" file. END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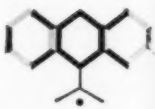

Office Hours? I've Had Enough!

An established G.P. discovers the advantages of an appointment system—and the art of switching to it

By Eli Eichelberger, M.D.

I suppose there are very few doctors who wouldn't agree, in principle, that it's better to see patients by appointment than to hold open office hours. But agreement in principle isn't agreement in practice. I know many physicians who hesitate to make the switch, chiefly because their patients have grown accustomed to the old way. In my opinion, such physicians are making a mistake.

Until a year ago last November, I myself clung to the open-hours routine. Then I decided to change. And the appointment system has done me and my practice so much good that I'd like to tell other doctors about the switch.

When I first began practice back in the Thirties, open office hours were the standard thing for us G.P.s. Times were bad. It seemed sensible to make oneself as available to patients as possible. So I was on tap from 1 to 3 six afternoons a week and from 7 to 9 on four evenings.

My patients didn't complain about the system. Nor did

THIS ARTICLE *has won one of the 1957* MEDICAL ECONOMICS *Awards for its author, who has practiced in York, Pa., for nearly twenty-five years.*

I—at least during the next few years. But I soon realized that it was far from ideal.

For one thing, I never knew what my patient load would be. Sometimes the office got crowded, and I had to work under pressure. There were days when visitors had to wait from forty-five minutes to an hour before I could see them. Other times, only one or two patients came in, and I was left to twiddle my thumbs.

His After-Hours Club

For another thing, the long and frequent office periods weren't always long enough for me to handle all necessary procedures. For instance, if a patient needed a complete physical or an insurance examination, I had to schedule it after regular hours.

As I've said, though, I went along with the system. It wasn't until after World War II that I began to consider a change. Younger men who'd moved into our area were seeing patients by appointment only—and doing very well, too. My colleagues and I discussed the possibility of following their example.

It wasn't an easy step to take. Our patients were used to coming in when it suited them, not necessarily when it suited us. How, we wondered, might they react to the new idea?

We kept on wondering. We grew older and busier. Finally, I determined to hesitate no longer: I'd at least try the new system for a while. If it didn't work, I could always drift back into the traditional groove.

In November, 1956, I put a sign in my waiting room stating that from January on, patients would be seen by appointment. Note that I avoided saying "by appointment *only*." I omitted the last word because I knew that at first some patients would just drop in. I didn't want to offend them. I was playing it cautiously.

Some Were Sarcastic

I then began to give appointment cards to people I'd have to see after the first of the year. Some made no comment. Several said things like: "Getting fancy, eh, Doctor? What was wrong with the old system?" And a number asked: "What happens if I really need you? Will I have to call a couple of days ahead for an appointment?"

I parried such questions as best I could. In particular, I

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stressed that if any patient were seriously ill, I'd fit him in regardless of appointments.

By January 1, we were ready to roll. We didn't roll smoothly right off, of course. Patients who didn't know I'd set up an appointment schedule came in without warning from time to time. It took tactful explaining to show them what was going on. Since I always tried to work them in, I also had to explain to other patients why we were often behind schedule.

But I soon found an easy way to solve the problem: By scheduling appointments farther apart,

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I allowed for breaks during which I could see the unexpected visitors. And as the weeks went on, there were fewer and fewer drop-ins.

Before long, in fact, my patients were sold on the system. Many of them expressed delight at being able "to get in to see you without that long wait." Others were pleased at no longer having to rush in so as to beat the crowd.

As for me—well, you won't find me changing back. I'm too well aware of all the following benefits I've gained from the new system:

I'm able to practice better medicine. My office is no longer too crowded or too empty. So I'm under no pressure to hurry one treatment in order to move on to the next. If I think a patient will need longer than the routine appointment period, I can schedule it that way in advance.

Then, too, I see patients more regularly and more often. In the old days, I used to tell a person who needed further care: "Drop by in a few weeks and I'll check you again." "A few weeks" often stretched into a few months. Now, the definite appointment

brings him in on a regular basis.

As a result, he's more apt to respond to treatment. For example, one of my patients is an overweight woman whom I've put on a diet. Because she knows she's going to see me at a specific time every two weeks, she's more inclined to watch her progress than she'd have been in the casual old days.

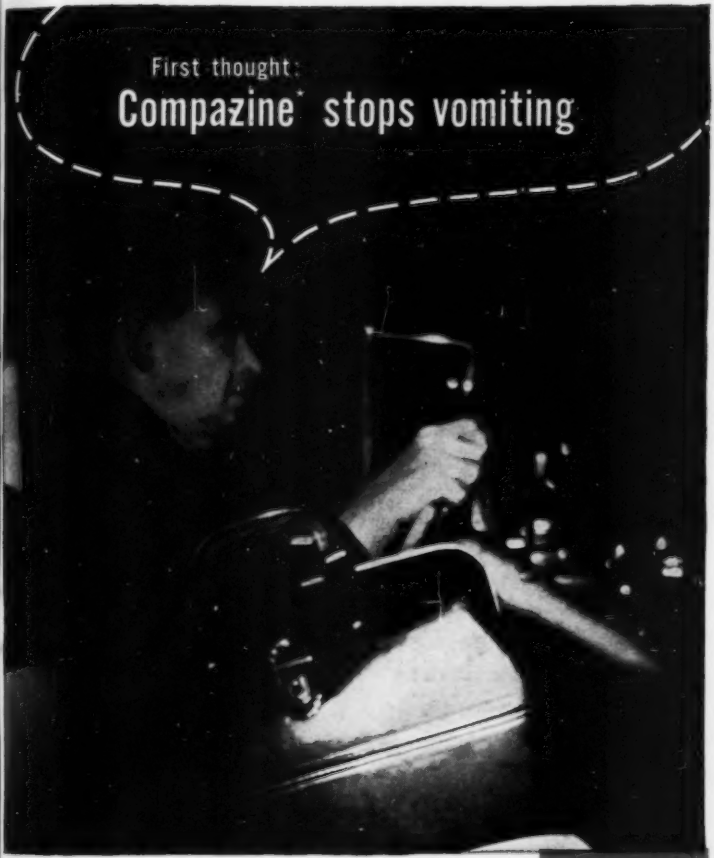
My patient relations are better than ever. People really appreciate unhurried care, I've discovered. Perhaps they think I'm more interested in them than I used to be.

My income has increased. During the first month of the appointment system, my collections jumped 10 per cent. My income stayed at the new level throughout 1957. The reason is plain: I saw more patients and saw them more frequently than in any year I've been in practice.

I have more free time. If I want to get away, I stop scheduling appointments. I take short breaks whenever I need them.

For instance, I used to hold office hours Saturday afternoons. Now I usually see patients only in the mornings. The new freedom has enabled me to play golf Saturday afternoons. I even play a better game than before.

Or take last spring, when my



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son wanted to visit some colleges before deciding which to enter. I earmarked some blank pages in my appointment book, and we took off for a few days. I'm a better doctor for occasional carefree vacations of that sort.

Are there disadvantages to the system? Not really. My office phone does ring almost constantly. It keeps one aide fairly busy just answering calls and scheduling appointments. But that's hardly a disadvantage.

There's also the chronic appointment breaker, who can raise hob with a carefully arranged schedule. But once I learn a patient isn't dependable, I generally give him no more appointments. Instead, I tell him that if he phones when he's ready to see me, I'll try to work him in.

In the few cases when appointments are unavoidably broken, I put the time to advantage by catching up on my reading or by chatting with a detail man. Or I stretch out my other appointments a bit.

For the first time in my professional life, I feel as if I'm running my office instead of letting it run me. I'm sure my patients would agree that it's running better, too. My only regret is that I didn't switch to an appointment system years ago. END

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Why It's Dangerous To Own Things Jointly

Better think twice about joint ownership of real estate, securities, an automobile, or even a bank account. It can cost your heirs plenty

By Melvin J. Goldberg

If you run down the list of property you own, you'll almost certainly find you hold some of it jointly with another person. Nothing could be easier to arrange. You both sign a standard bank form or mortgage application, and there you are—joint owners.

Maybe you've set up a joint bank account so both you and your wife can draw checks. Maybe you've put your home in joint names so she'll eventually get it without the need for legal proceedings. And so on.

Such joint ownership has its advantages. For instance, joint bank accounts and jointly held U.S. bonds are a fast and convenient source of cash if either of you should die. And the joint ownership of stock gives you and your wife an income tax deduction of up to $100 in dividends, instead of the $50 limit for individuals.

But there may also be great drawbacks to the simple sort of arrangement you're likely to have. It can mean extra taxes for you and your heirs. Even worse, it can result in your property's being parceled out in a way you'd never have dreamed of.

So if you've got any large amounts of property in joint names, you'd better pause long enough to mull over the legal traps. (Some set-ups, as we'll see later, have special safeguards. But they also have special rules. So in most of the following discussion we'll be talking about joint ownership of the simplest and most typical nature.)

Control Is Forfeited

Once your property is put in joint names, it's no longer yours to dispose of. No matter what disposition you may make of it in your will, jointly owned property goes automatically to the surviving owner. Here's what can happen:

A Detroit physician and his wife held almost everything jointly. They had no children but were the sole support of the doctor's invalid father. The doctor's will gave one-third of his estate to his father, the rest to his wife.

When the couple was involved in an automobile accident, the doctor died immediately, his wife a few days later. At the instant the doctor died, their jointly held property belonged to his wife. At her death, since she had no will, it went to her relatives.

The share of the doctor's father? A few hundred dollars—one-third of the physician's meager amount of separately owned property.

By holding your property in joint names, you forfeit all control over who gets it at your death. You cut off all other heirs. You lose the flexibility to adapt your estate

plan to changing family circumstances.

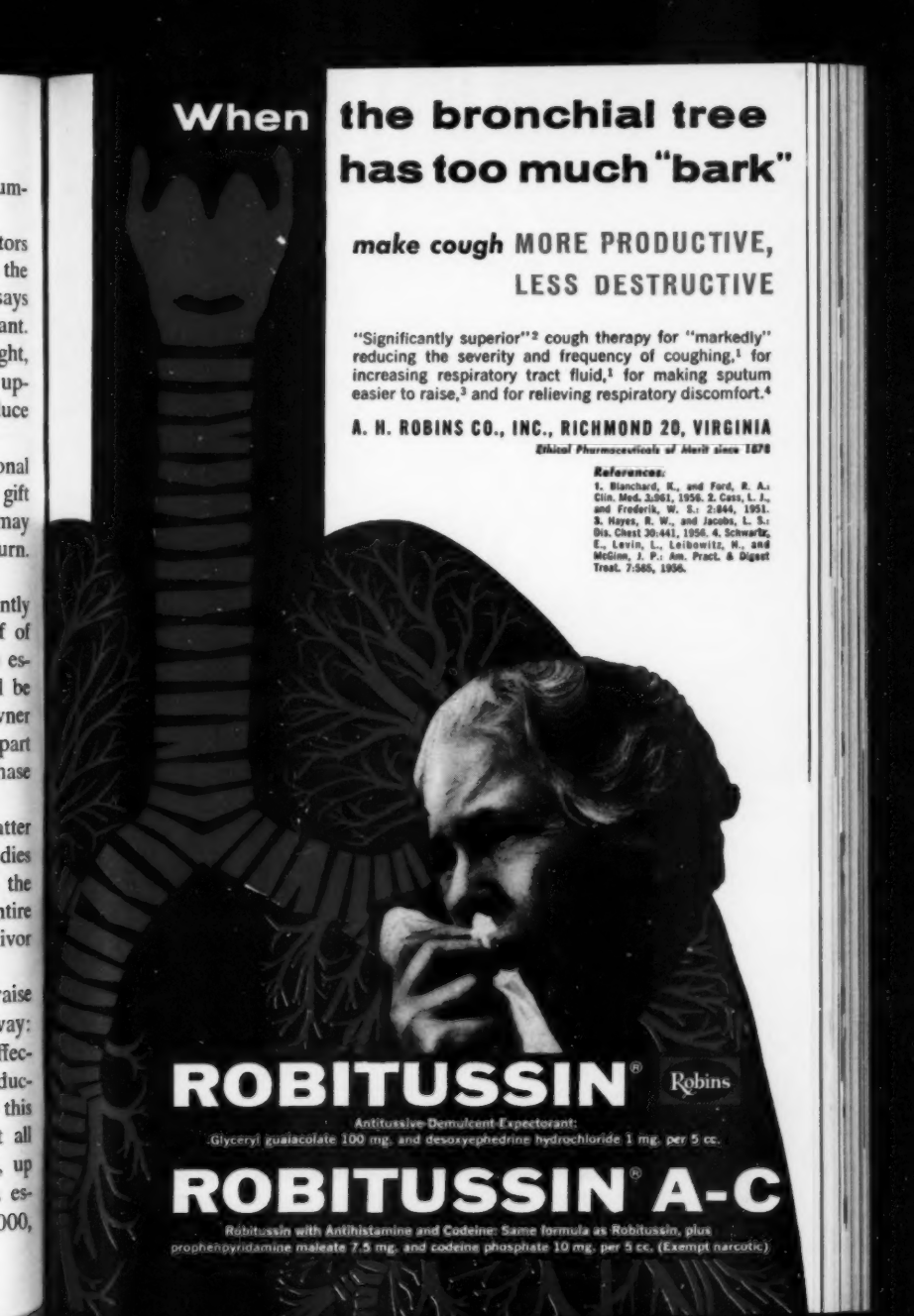
"We find that many doctors choose joint ownership in the hope it'll cut their taxes," says one estate-planning consultant. "It'll change their taxes, all right, but in only one direction: upward. It can't possibly reduce them."

All three kinds of personal taxes—the estate tax, the gift tax, and the income tax—may be affected. Take them in turn. To begin with, estate taxes:

When you die, all your jointly held property (not just half of it) must be reported on the estate tax return. And it'll all be taxed unless the surviving owner can prove he contributed part or all of the original purchase price.

It works that way no matter which of the joint owners dies first. The law assumes that the first to die paid for the entire property. It's up to the survivor to prove otherwise.

Joint ownership can also raise your estate tax in another way: by denying you the most effective use of the "marital deduction." Generally speaking, this allows your wife to deduct all the property you leave her, up to half your adjusted gross estate. On an estate of $200,000,


When the bronchial tree has too much "bark"
make cough MORE PRODUCTIVE, LESS DESTRUCTIVE
"Significantly superior"[2] cough therapy for "markedly" reducing the severity and frequency of coughing,[1] for increasing respiratory tract fluid,[1] for making sputum easier to raise,[3] and for relieving respiratory discomfort.[4]
A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA
Ethical Pharmaceuticals of Merit since 1878
References:
1. Blanchard, K., and Ford, R. A.: Clin. Med. 3:661, 1956. 2. Cass, L. J., and Frederik, W. S.: 2:844, 1951. 3. Hayes, R. W., and Jacobs, L. S.: Dis. Chest 30:441, 1956. 4. Schwartz, E., Levin, L., Leibowitz, N., and McGinn, J. P.: Am. Pract. & Digest Treat. 7:565, 1956.
ROBITUSSIN®
Robins
Antitussive-Demulcent-Expectorant:
Glyceryl guaiacolate 100 mg. and desoxyephedrine hydrochloride 1 mg. per 5 cc.
ROBITUSSIN® A-C
Robitussin with Antihistamine and Codeine: Same formula as Robitussin, plus
pheniramine maleate 7.5 mg. and codeine phosphate 10 mg. per 5 cc. (Exempt narcotic)

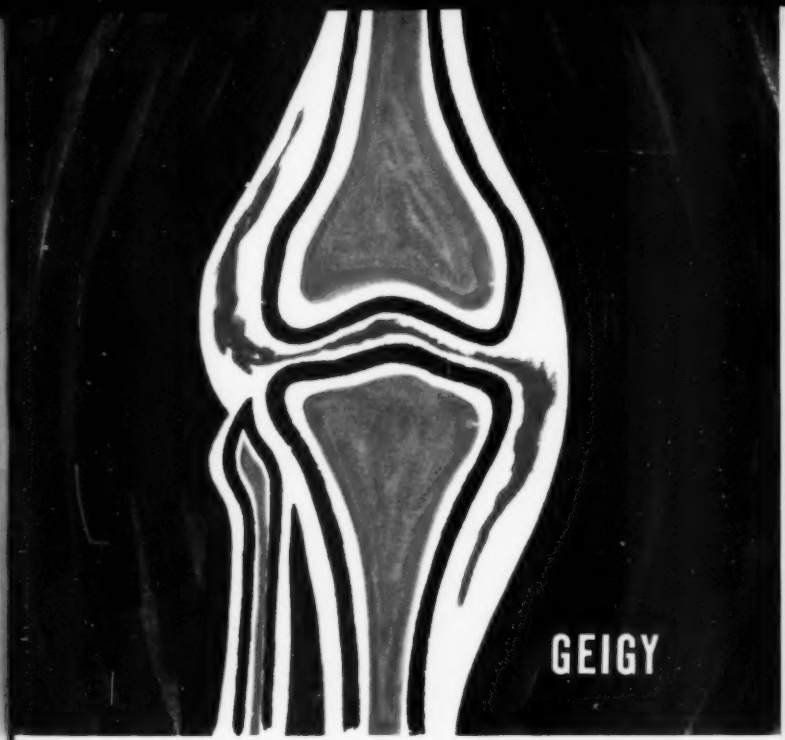
she could get a marital deduction of up to $100,000.

But let's suppose you and she own your entire $200,000 estate jointly. In that case, she gets everything when you die. Because of the $100,000 marital deduction and the $60,000 statutory exclusion, she'll have to pay taxes on only $40,000—a tax bill of about $4,800. So far so good.

However, when *she* leaves the money to your children, the tax collector will take a second swipe at the estate. And it'll be a bigger one this time. Since the marital deduction won't apply, your children will have to pay about $31,000 in taxes.

On the other hand, suppose you'd held all the property in your own name. You could then have left part of it in trust for the children. The estate tax would be the same. MORE▶

"Of course you hate yourself—you have every reason to."



NOW—in arthritis and allied disorders a new form

BUTAZOLIDIN® alka capsules

Provides the potent anti-inflammatory, analgesic and antipyretic action of BUTAZOLIDIN plus an added antacid-antispasmodic effect for the benefit of patients with gastric sensitivity.

nonhormonal • anti-inflammatory • anti-arthritic

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for detailed literature before instituting therapy.

BUTAZOLIDIN® Alka: Capsules containing Butazolidin (phenylbutazone GEIGY) 100 mg.; aluminum hydroxide 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

BUTAZOLIDIN® (phenylbutazone GEIGY): Red coated tablets of 100 mg.

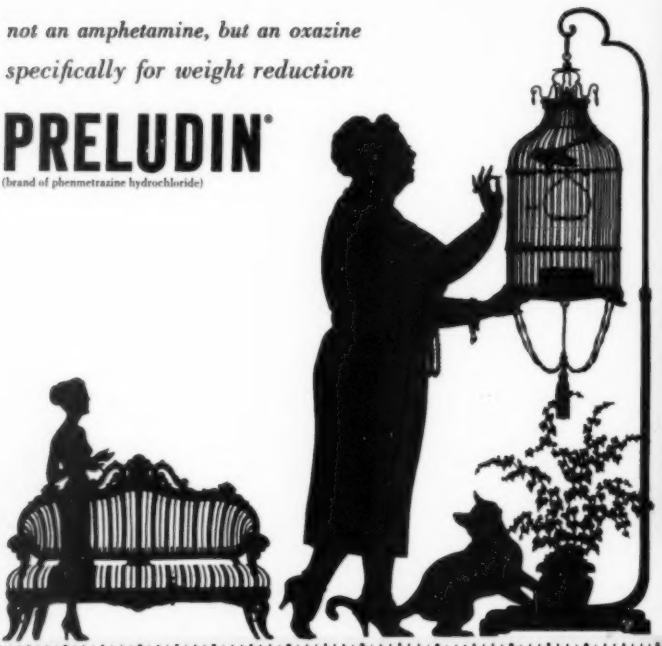
BU-875

not an amphetamine, but an oxazine

specifically for weight reduction

PRELUDIN®

(brand of phenmetrazine hydrochloride)



2 5|1 5|0 4|9 4|8 4|7 4|6 4|5 4|4 4|3 4|2

Chemically and pharmacologically different from amphetamine, PRELUDIN is a potent appetite suppressant having minimal C.N.S. stimulating activity.[2]

reduces the problems of reducing — PRELUDIN produces satisfactory weight loss with little or no undesirable side actions such as insomnia or "jitteriness."[1,3] Hence, PRELUDIN can often be administered where other appetite suppressants are rejected.[2]

facilitates the treatment of complicated obesity — PRELUDIN may be used in cases of moderate hypertension, chronic cardiac disease or diabetes.[1,4]

(1) Barnes, R. H.: A Program of Therapeutic Supports in Obesity, Scientific Exhibit, 106th Ann. Meet., A.M.A., New York, N.Y., June 3-7, 1957. (2) Natenshon, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956. (3) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (4) Holt, J. O. S., Jr.: Dallas M. J. 42:497, 1956. (5) Ressler, C.: J.A.M.A. 165:135 (Sept. 14) 1957.

PRELUDIN® (brand of phenmetrazine hydrochloride). Scored, square, pink tablets of 25 mg. Under license from C. H. Boehringer Sohn, Ingelheim.

original silhouette hand cut by Mochi

GEIGY

Introductory Combination Offer!

. . . the **NEW** professional foot operated **SEPTISOL JR. DISPENSER** price $13.95 and ONE GALLON OF **SEPTISOL ANTISEPTIC LIQUID SOAP** . . . price $6.75 per gallon.

The NEW SEPTISOL Jr. Dispenser . . . a new foot-operated soap dispenser that functions exactly as the famous SEPTISOL® dispenser, which is used in hospitals throughout the world. All materials in contact with soap are stainless steel and plastic . . . assuring clean, aseptic soap with a touch of the toe. *Professional in appearance—professional in action.* UNCONDITIONALLY GUARANTEED FOR 2 YEARS.

Septisol Concentrated Antiseptic Skin Detergent. The surgical soap of choice in over 3,000 hospitals throughout the United States . . . used in the offices of over 25,000 physicians and dentists.

ACT NOW

THIS OFFER GOOD ONLY UNTIL MAY 31, 1958.

SEND THIS COUPON ➡

FOR YOUR SEPTISOL JR. DISPENSER AND GALLON OF SEPTISOL.

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Gentlemen: I'd like to take advantage of this Special Combination Introductory Offer.

Please send me _____ **SEPTISOL JR. DISPENSERS**
Please send me _____ **GALLONS OF SEPTISOL**

Name_____

Address_____

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My Dealer_____

But a large part of the second tax on your wife's estate could have been avoided. The reason: By leaving a large sum in trust for your children, you keep it from becoming part of your wife's estate.

The difference in total taxes could amount to as much as $24,000.

Gift Taxes, Too

When you pay for a piece of property and put it in your wife's name as well as yours, you have in effect made a gift of half the cost. If the value of the gift exceeds the statutory exclusion, you're supposed to file a gift tax return. If you don't pay such a tax, you risk consequent interest and penalties.

There's one exception to that rule: When you buy a house and put it in joint names with your wife, you don't have to file or pay the tax. But should you later sell the house, the money must all go to you. If your wife gets any, you'll then have to pay a gift tax.

The exception applies only to real estate. And it doesn't apply if you own the property with anyone other than your wife.

Everything you own takes on a new tax basis in your estate after your death. That means

The psychological needs of the elderly confront physicians with one of their most perplexing problems. Perhaps no other patient group suffers so much from emotional distress. Yet, precisely because of their age, geriatric patients often seem beyond the reach of tranquilizing treatment.

When tranquilization seems risky . . .

They are too much beset by complicating chronic ailments, too susceptible to serious side effects. Ataraxia is clearly indicated, yet the doctor cannot risk side reactions on liver, blood or nervous system.

Is there an answer to this dilemma?

We feel there is. In four recent papers investigators have reported good results with ATARAX in patients up to 90 years of age.* In one study, **improvement was "pronounced" in 76%, "good" in an additional 18.5%.*** ATARAX has been successfully used in such cases as senile anxiety, agitation, hyperemotivity and persecution complex.* On ATARAX, patients became ". . . quieter and more manageable. They slept better and demonstrated improved relations with other patients and hospital personnel. Even their personal hygiene improved, and they required less supervisory management."*

. . . ATARAX is safe

Yet even in the aged, ATARAX has given "no evidence of toxicity. . . . Complete liver function tests and blood studies were made on all patients after two months of therapy. . . . There were no significant abnormalities."* With still other elderly patients "tolerance to the drug was excellent, even in cases where the patients were given relatively high doses."* Similarly, no parkinsonian effects have been observed on ATARAX therapy.

Nor does ATARAX make your patients want to sleep all day. Instead, they can better take care of themselves, because ATARAX leaves them both calm and alert. In sum, ATARAX ". . . does not impair psychic function and has a minimum of side effects. . . . It appears that ATARAX is a safe drug. . . ."*

These, undoubtedly, are the results you want when emotional problems beset your geriatric patients. For the next four weeks, won't you prescribe tiny ATARAX tablets or pleasant-tasting ATARAX syrup – both so readily acceptable to the elderly.

*Documentation on request

ATARAX®
(BRAND OF HYDROXYZINE)

M. A. Sidell M.D.
Medical Director

ROERIG Rx

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

that if an item has increased in value since the time you bought it, your heirs need not pay a capital gains tax on the increase when they sell the item. They'll pay such a tax only on any increase in value since the time they inherited it.

If you've held it jointly, though, only your share of it may get this favorable treatment. Here's an example that illustrates this point:

Suppose you and your wife contribute equally toward a $20,000 piece of property and put it in your joint names. Later it increases in value to $30,000. Even though your wife paid her share, all of it will be included in your estate when you die unless she has proof that she paid half the original cost. If she has such proof and doesn't use it, the entire property will take on a new tax basis of $30,000. So she'll never have to pay a capital gains tax on the $10,000 increase.

But what if she decides to claim that you paid for only half the item? (She might well do so in order to save estate taxes.) In that event, her half of the property will be denied the new tax basis. So if she sells it, she'll be required to pay the tax on the $5,000 that represents her share of the increase.

Types of Ownership

Finally, if you own any property jointly, you'll do well to know exactly what sort of arrangement you have. There are four major types of joint ownership. They're tailor-made for certain situations; but you may be involved in one or more of the wrong kind. Re-examine your holdings in the light of the following paragraphs:

1. *Joint tenancy.* If you have a joint-and-survivor bank account or joint U.S. savings bonds, it's a joint tenancy. In other words, you and the other owner have equal right to the property while you're both alive. Legally, either of you may dispose of the entire asset without the other's knowledge. And at the death of either, the entire property goes to the other automatically, regardless of any will.

2. *Tenancy by the entirety.* This type is usually recognized only between husband and wife, and only for real estate. If you own a home with your wife, you probably hold it under such an agreement. It's like the ordinary

respiratory congestion orally

An orally administered decongestant has much better distribution to the mucous membranes of the respiratory tract than nasal sprays, drops and inhalants. "This affords opportunity for shrinkage in areas that could not be approached by sprays, drops or actual topical applications."

—MORRISON, L. F.: ARCH. OTOLARYNG. 59:49-53 (JAN.) 1954.

The Triaminic form and formulation, described in detail on the following pages, have proved remarkably effective as an oral decongestant.

STOP respiratory congestion orally

plus control of pain and fever

Congestion and associated discomforts of the common cold can now be treated *orally* with a single preparation — Triaminicin. Containing effective amounts of Triaminic for rapid clearing of the bronchial and nasal passages, Triaminicin also provides aspirin, phenacetin and caffeine to control headaches and fever. Triaminicin Tablets are buffered.

In addition, Triaminicin contains vitamin C to help raise resistance[1,2,3] to respiratory conditions.

1. Macleod, G., and Sherman, H. C., in Handbook of Nutrition, ed. 2, New York, The Blakiston Company, 1951, p. 254. 2. Brody, H. D.: J. Am. Dietet. A. 29:580, 1953. 3. Franz, W. L., and Heyl, H. L.: J.A.M.A. 162: 1224, 1956.

Each buffered Triaminicin Tablet contains:

TRIAMINIC® (Phenylpropanolamine hydrochloride 25 mg., Pyrilamine maleate 12.5 mg., Pheniramine maleate 12.5 mg.)	50 mg.
Aspirin (3½ gr.)	225 mg.
Phenacetin (2½ gr.)	150 mg.
Caffeine (½ gr.)	30 mg.
Ascorbic acid	50 mg.
Aluminum hydroxide (dried gel)	180 mg.

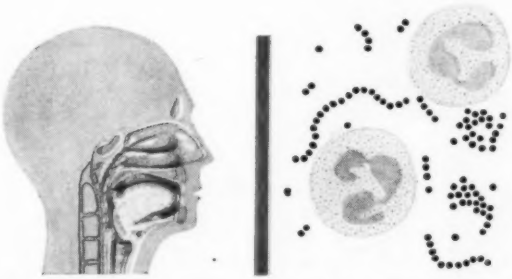
Dosage: 1 tablet every 3 or 4 hours.

NEW Triaminicin tablets

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

STOP respiratory congestion orally

plus control of bacterial invaders



With one unique preparation, you can now provide dramatic relief from respiratory congestion, and at the same time protect the patient from secondary bacterial infection. Through the action of Triaminic, its oral decongestant component, nasal patency is often effected within minutes of the first dose; breathing is easy again.

When bacterial invasion threatens, Trisulfaminic offers the wide-spectrum protection of triple sulfas. It is particularly valuable for the "almost well" patient recovering from endemic or epidemic influenza, and the patient prone to "lingering" or recurrent colds. And in purulent rhinitis, sinusitis and tonsillitis, Trisulfaminic offers a more realistic approach to the total treatment of the patient.

Each tablet or 5 ml. tsp. contains:

Triaminic . . . . . 25 mg.
(Phenylpropanolamine hydrochloride 12.5 mg., Pyrilamine maleate 6.25 mg., Pheniramine maleate 6.25 mg.)
Trisulfapyrimidines U.S.P.....0.5 Gm.

Dosage: Adults—2 to 4 tablets* initially, followed by 2 tablets every 4 to 6 hours until the patient has been afebrile for 3 days.

Children—8 to 12 years— 2 tablets initially followed by 1 tablet every 6 hours. Younger children in proportion.

**Each 5 ml. tsp. of Suspension equals 1 tablet.*

NEW Trisulfaminic tablets and suspension

TRIAMINIC© WITH TRIPLE SULFAS

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

Frenquel may mean re-entry to the family circle for many of your confused, elderly patients

JOINT OWNERSHIP

joint tenancy, with the following difference: The property can't be disposed of without the assent of both owners.

Both the above arrangements may work well enough between you and your wife or another close family member. But they're not advisable for property in a medical partnership. If either you or your partner should die, all the joint property would go to the survivor; the widow would get nothing. A third form of multiple ownership is much better suited to such set-ups.

3. *Tenancy in common.* If you own property as a tenant in common, you don't forfeit your interest at death. It's still yours, and you can dispose of it in your will. Such co-ownership may be your best protection in a partnership situation.

4. *Community property.* This is involuntary joint ownership. It applies only if you live in Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, or Washington State. The laws of those eight states impose a special kind of co-ownership on husbands and wives. The regulations vary somewhat from state to state. If they affect you, better bone up on them.

As I indicated earlier, tenancy

JOINT OWNERSHIP

in common and community property have their own particular rules. This article has dealt mainly with the kind of set-up—joint tenancy and tenancy by the entirety—you and your wife probably have if you live outside the eight community-property states.

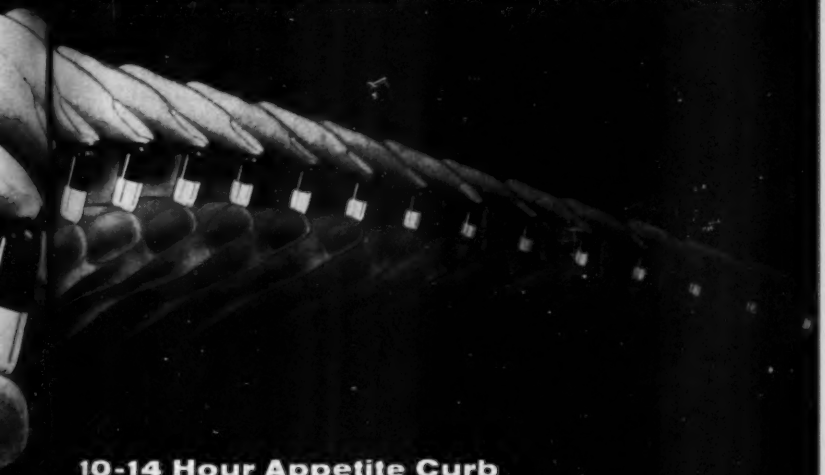
To sum up, such arrangements can't take the place of a will. In fact, they can *displace* your will. And that's bad. A will can do everything for you that joint ownership can. Furthermore, it can do it a lot better and more cheaply. END

ARI VERWEIGHT FROM OVEREATING

℞

BIPHETAMINE®

A STRASIONIC® RELEASE PRODUCT RESIN



10-14 Hour Appetite Curb
without fatiguing surges of stimulation but with an increased feeling of well being.

Single Capsule Daily Dose
'Strasionic' release is sustained ionic release proceeding at a uniform, controlled rate in both stomach and intestines, eliminating sharp rises and declines in blood levels.

Predictable Weight Loss
Rx Biphetamine capsules containing a mixture of equal parts of amphetamine and dextro amphetamine in the form of a resin complex. Three strengths—Biphetamine 20 mg., 12½ mg., 7½ mg.

*A leading life insurance company statistic

MYALGIA

a better drug

The action of aspirin is markedly improved by intermixture with the antacid MAALOX.® This combination is available on physicians' prescriptions as

Ascriptin

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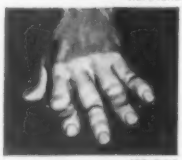
HEADACHE



ARTHRITIS

COLD

Each tablet contains:

ACETYLSALICYLIC ACID..... 0.30 Gm.
MAALOX..... 0.15 Gm.
(*Magnesium aluminum hydroxide gel*)

Note these advantages:

1. Within one hour, more than double the amount of salicylate appears in the blood stream.
2. Pain relief is felt twice as fast.
3. Gastric disturbance seldom occurs.
4. Pain relief lasts appreciably longer.

Prescribe ASCRIPTIN-Rorer for the pains and discomfort of arthritis, rheumatism, colds, grippe, headache, Asian Influenza, muscular aches and pains, etc. Your patients will be grateful.

Offered in bottles of 100 and 500 tablets.
Available at prescription pharmacies.
Liberal samples promptly on request.

Capsules ASCRIPTIN *with Codeine Phosphate 15 mg. also offered.*

ETHICAL PHARMACEUTICALS SINCE 1910
PHILADELPHIA 44, PA.

WILLIAM H. RORER, INC.

RORER

'My Most Interesting House Call'

By William N. Jeffers

This is the fifth and final article in a series based on MEDICAL ECONOMICS' survey of doctors' house-call habits. In preceding articles, national patterns were pointed out and general conclusions drawn. But you'll find neither patterns nor conclusions in the following pages.

What you will find is a selection of true adventure tales, told in the surveyed doctors' own words. They're in answer to the question: "What's the most interesting house call you've ever made?"

* * *

A Minnesota pediatrician tells this one:

During a polio epidemic, a frantic mother phoned that whenever she'd try to raise her 2-year-old's head from the bed, he'd scream, and she couldn't budge him. I went at once and found the condition as described.

The cure: removing a large wad of bubble gum that had cemented the child's hair to the mattress.

* * *

And another mother-and-child story comes from a

physician down in Tennessee:

A stranger phoned to ask me to come see her little boy, who had a temperature of 104. I scribbled down the address and rushed over to a neighborhood and a house that I'd never visited before. There I was met by a young woman and a toddler. I immediately asked what the temperature was now.

"Oh," said the mother, "I think it's about 80."

I told her this couldn't be. "O.K.," she said. "I won't argue about it." I blinked, then started to examine the child. He seemed perfectly healthy.

Suddenly I saw the light. "Say," I said, straightening up, "are you Mrs. Everett?"

"Why, no," she said. "I'm Mrs. Williams."

I was at the wrong house. I couldn't help asking: "And who'd you think *I* was?"

"I don't know," she answered;

The Achievement in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone.[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]... absence of serious side effects specifically noted.[1, 2, 3]

The Achievement in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]... 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

Aristo

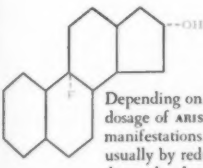
1. Rein, C. R., Fleischmajer, R., and Rosenthal, A. L.: J. A. M. A. 165:1821, (Dec. 7) 1957.
2. Shelley, W. B., and Pillsbury, D. M.: Personal Communication.
3. Sherwood, A., and Cooke, R. A.: Personal Communication.
4. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957.
5. Hartung, E. F.: Personal Communication.
6. Schwartz, E.: Personal Communication.
7. Sherwood, A., and Cooke, R. A.: J. Allergy 28:97, 1957.
8. Hellman, L., Zumoff, B., Kretshmer, N., and Kramer, B.: Paper presented at Nephrosis Conference, Bethesda, Md., Oct. 26, 1957.
9. Ibid.: Personal Communication.
10. Barach, A. L.: Personal Communication.
11. Segal, M. S.: Personal Communication.
12. Cooke, R. A.: Personal Communication.
13. Dubois, E. L.: Personal Communication.

The Achievement in Respiratory Allergies: **"Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]**

The Achievement in Other Conditions: **Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8, 9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10, 11, 12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]**

tocort®

Triamcinolone LEDERLE



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will supress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

"some kind of thermometer salesman, I guess."

* * *

A Texas doctor tells about an even more cooperative mother:

I arrived to handle a home delivery for a 48-year-old woman in labor with her eleventh baby. She told me she felt sympathetic toward me because I was so young and so new in the community. That, she said, was why she'd waited for me to get there, although she *could* have delivered at any time during the past hour.

I suggested she do so without further delay. She did—before I could put my bag down.

* * *

An OB incident that might strain your credulity, but that a Western general surgeon vouches for:

One morning at dawn I made a call on a woman who'd just had a spontaneous abortion. The tiny fetus had been put in the garbage pail, but I noticed it breathed and moved a little. Wrapping it in a towel, I put it in my overcoat pocket—and completely forgot it until afternoon. Then I rushed it to the hospital, where it was admitted weighing fourteen ounces.

Today he weighs over 200 pounds!

* * *

A Michigan G.P. tells of a rugged character at the other end of the age span:

I was called to a farmhouse to attend a 92-year-old man. Being "tired of living," he'd taken a razor and had sawed his neck, wrists, and arms in sixty or seventy places. Then he'd crawled out of the house as far as the gate.

However, since the cuts weren't deep enough, and he had low blood pressure, he hadn't bled much. The old fellow recovered, got religion, and lived four more years.

* * *

Obviously, you just can't hold some patients down. A South Carolina man tells this story:

One night, a man phoned to ask me to come out to his farm to see his wife. He thought she had pneumonia. When I got there, I entered through the back door into the kitchen. The man was cooking supper. As soon as he saw me, he ran off. In a minute he returned, shaking his head.

"I'm heap-sorry, Doc," he said, "but I thought I'd see you

in

...HYPERTENSION

Rx ESKASERP*

reserpine, S.K.F.

SPANSULE*

sustained release capsules, S.K.F.

especially useful as initial antihypertensive therapy

1. Provides gentle, long-lasting relaxation
2. Lowers blood pressure gradually and keeps it down
3. Minimizes side effects because of smooth, sustained release of reserpine over a prolonged period
4. Provides maximum patient convenience . . . only one or two doses daily
5. Low in cost

Available: 0.25 mg. and 0.50 mg.

Smith Kline & French Laboratories, Philadelphia

first ⧗ in sustained release oral medication

*T.M. Reg. U.S. Pat. Off.

drive up and could run hold my wife in bed. She's scared to death of doctors. I was too late, though. She's hiding in one of them ditches in the pasture, and now we'll never find her. Just leave her some medicine."

* * *

And then there are the hazards of being called merely for "consultation." Here's an instance as told by a Pennsylvania pediatrician:

I was called out to see an infant who apparently wouldn't take nourishment. He would suck at the bottle a couple of times, I was told, and would then cry and refuse to continue. I found the infant in a bassinet under a blue electric light, with a powwow woman muttering incantations over him.

I picked up the child and saw he was healthy and vigorous. Then I examined the bottle, an early Evenflo type. It was in good shape—except that the top was screwed on so tightly no milk could pass. I loosened the top and sat down with the child. He eagerly drank the whole bottleful.

Out of the corner of my eye, I saw the father slip money into the hand of the powwow woman. And my bill? They never did pay it. END

FIRST—clinically confirmed for better management of psychotic patients

NOW—clinically confirmed as an improved antiemetic agent

VESPRIN

Squibb Trifluopromazine

PROMPT, POTENT and LONG-LASTING ANTIEMETIC ACTIVITY

Clinical investigators report that in clinical studies*

Postoperatively	After Nitrogen Mustard Therapy	In Chronic Nausea and Vomiting	In Infections, Intra-abdominal Disease, and Carcinomatosis	In Neurosurgical Diagnostic Procedures	In Pernicious Vomiting of Pregnancy

VESPRIN

- showed potent antiemetic action
- completely relieved nausea and vomiting in small intravenous doses
- showed a prolonged antiemetic effect
- caused little or no pain at injection site
- controlled chronic nausea and vomiting in orally administered doses
- produced relief in cases refractory to other antiemetics
- often markedly depressed or abolished the gag reflex
- terminated with singular effectiveness the hard-to-control nausea and vomiting common to nitrogen mustard therapy
- provided superior prophylaxis against the nausea and vomiting associated with pneumoencephalography

*Reports to the Squibb Institute for Medical Research

antiemetic dosage: *Intravenous route*—2 to 10 mg. for therapy or prophylaxis
Intramuscular route—5 to 15 mg. for therapy or prophylaxis
Oral route—Prophylactic doses may range from 20 to 30 mg. daily

supply: *Parenteral Solution*—1 cc. ampuls (20 mg./cc.)
Oral Tablets—10 mg., 25 mg., 50 mg., in bottles of 50 and 500

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Squibb Quality—the Priceless Ingredient

Authoritative studies provide

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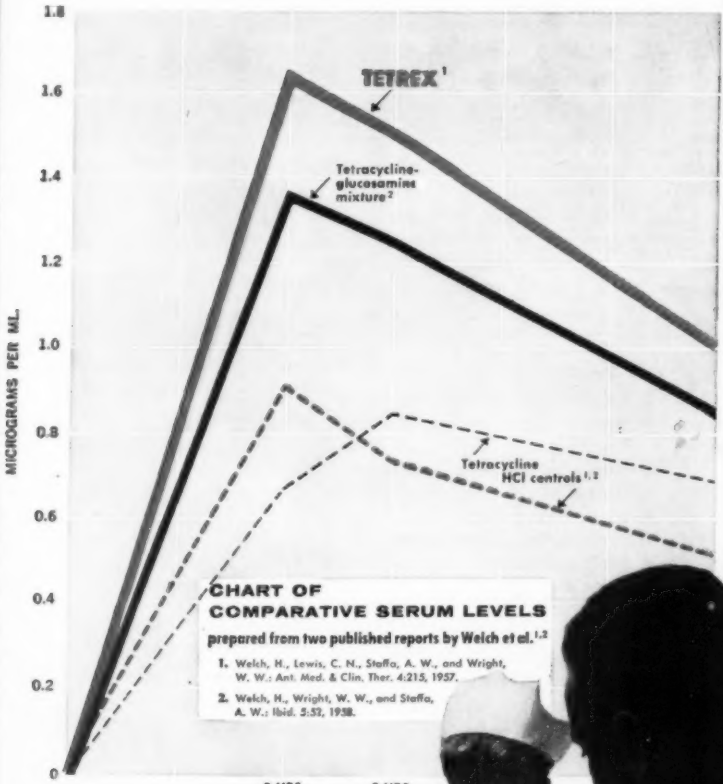
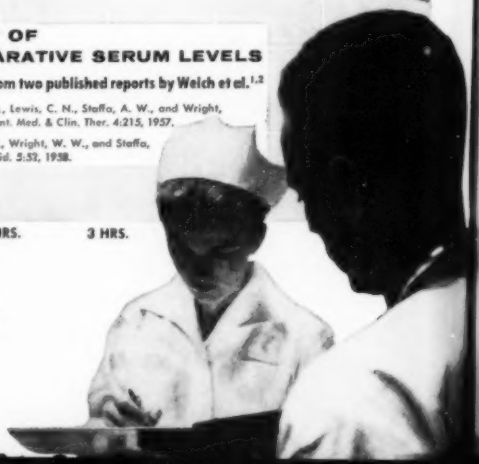


CHART OF COMPARATIVE SERUM LEVELS

prepared from two published reports by Welch et al.[1,2]

1. Welch, H., Lewis, C. N., Staffa, A. W., and Wright, W. W.: Ant. Med. & Clin. Ther. 4:215, 1957.
2. Welch, H., Wright, W. W., and Staffa, A. W.: Ibid. 5:52, 1958.



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THE ORIGINAL TETRACYCLINE PHOSPHATE COMPLEX

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Significant data on tetracycline serum concentrations are contained in a chart summary of two separate studies by Welch et al.,[1,2] showing the average serum concentrations after the administration of (1) a single capsule of TETREX (tetracycline phosphate complex)... (2) a single capsule of a mixture of tetracycline HCl and glucosamine HCl... and (3) single capsules of tetracycline HCl. Serum levels for TETREX were highest at all three test periods – 2, 3 and 6 hours after administration– despite the fact that the capsules containing the tetracycline-glucosamine mixture were determined by assay to be excessively overfilled.*

*Tetracycline-glucosamine mixture, 310 mg.; TETREX, 268.8 mg.; tetracycline HCl control for TETREX, 256 mg., and tetracycline HCl control for tetracycline-glucosamine mixture, 270.8 mg.

–impressive clinical record, too!

- **More than 170 million doses of tetracycline phosphate complex during 1957.**
- **Clinical reports on Tetrex by 9 investigators[3,4,5,6,7] on 996 patients published during 1957.**
- **Tetrex is a *pure broad-spectrum antibiotic* — not a mixture. Needs no potentiators or additives.**
- **"All patients infected with tetracycline-sensitive organisms responded satisfactorily to [Tetrex] therapy."[3]**

REFERENCES: 3. Cronk, G. A., Naumann, D. E., and Casson, K.: Fifth Annual Symposium on Antibiotics, Washington, D. C., Oct. 2-4, 1957. 4. Cronk, G. A., and Naumann, D. E.: Ant. Med. & Clin. Ther. 4:166, 1957. 5. Prigot, A., Shidlovsky, B. A., and Felix, A. J.: Ibid. 4:287, 1957. 6. Putnam, L. E.: Ibid. 4:470, 1957. 7. Rein, C. R., and Fleischmajer, R.: Ibid. 4:422, 1957. See also Report by A.M.A. Council on Drugs, J.A.M.A. 166:52, 1958—to be published in New and Nonofficial Remedies.

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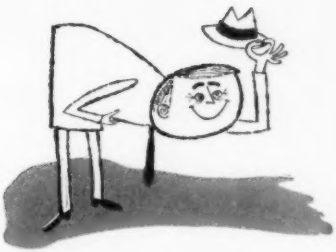


These Little Notes Pay Big Dividends

Here are model ways to let your colleagues know you're grateful for their services to you

By John E. Eichenlaub, M.D.

A young doctor asked the chief of staff of our hospital how he could get better acquainted with other doctors in town. "Thank them," the older man said. "Even if they don't know who you are, thank them for everything they do that benefits you."

To explain what he meant, he added: "When another doctor on the staff presents a paper you find stimulating, go up and tell him so. When you find that the speaker at the P.T.A. is a fellow doctor, thank him on behalf of the organization for his time and trouble. If you read a helpful article by a local man, drop him a note to thank him for writing it."

"But won't that seem phony?" the young man asked.

"Not if you really feel it. I'm not recommending false effusiveness. I'm suggesting that you be alive to the favors and benefits you actually get from your colleagues, and that you be willing to say 'thank you' for them. Cultivate

those qualities and you'll find yourself more than welcome in this or any other medical community."

I was the tyro doctor in that story. I took the older man's advice, and I'm still taking it—with gratitude. I've learned how much thanks mean to me as well as to my colleagues. So lately I've been collecting good examples of thank-you notes.

Here are some that I believe especially appropriate for use in the most typical situations that doctors can ordinarily expect to meet.

For Sending a Patient

Thanks for referrals. A simple, direct note like the following is sure to please the referring physician:

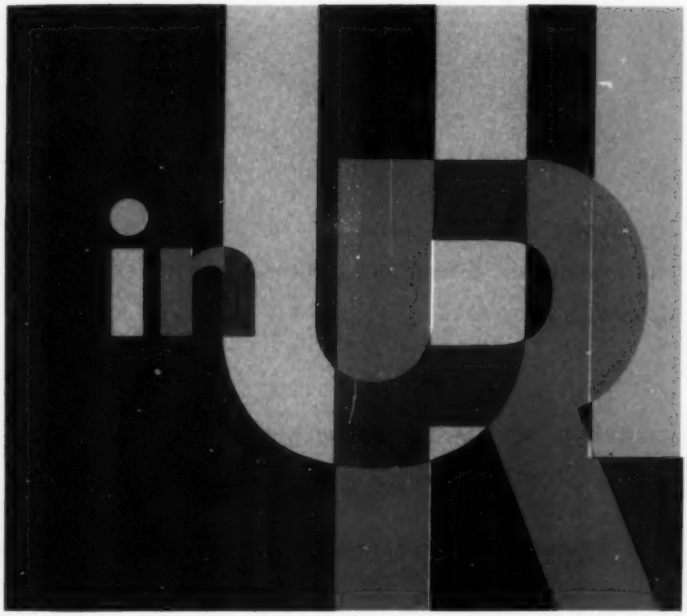
"Thank you, Dr. Peters, for referring Alvin Jones to me for diagnostic study. He has an appointment on Friday, April 18. You'll hear from me shortly thereafter concerning my findings."

Every phrase in the above note has a purpose. You include the reason for the referral—consultation, diagnostic study, operation, future management of the principal complaint, or whatever—so that the other doctor can straighten out misunderstandings, if any, before you see the patient. The date is important, especially if you can't see the patient right away. It keeps the other doctor from worrying about what's going on. And the reference to a further report is equally reassuring.

Can such notes be handled by your office staff? Some specialists use printed cards or letters from an aide, with an opening statement like this: "Dr. Smith has asked me to express his thanks . . ." But many doctors have told me they resent the impersonal nature of such an acknowledgment. So it seems to me that the physician's own signature on the letter can win him a big bonus in goodwill.

More Than Polite

One surgeon with a large Midwestern practice sometimes goes a step beyond mere thanks for referrals. Whenever a doctor who hasn't sent him patients before does so, he adds a courteous invitation to his thank-you note. "It would be a pleasure to meet you personally," he might say. "Could you attend the next hospital staff meeting with me, and



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Gantrisin offers the advantage of an effective antibacterial with high solubility and little danger of renal complication.

Supplied: Tablets 0.5 Gm, bottles of 100, 500 and 1000.

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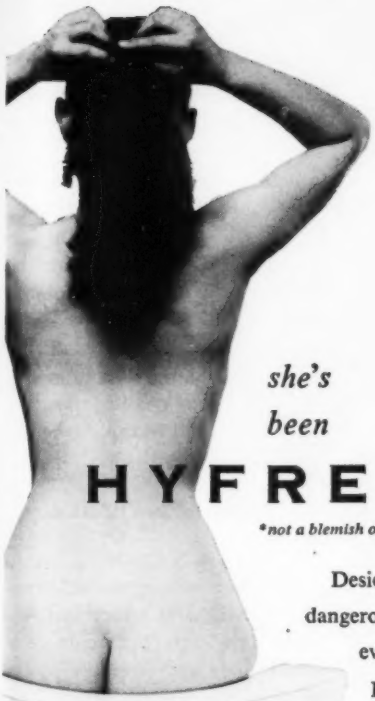

she's
been

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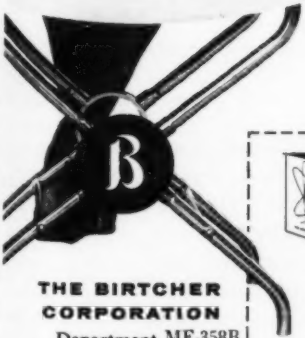

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Please send me your new full-color brochure showing step-by-step technics for removal of superficial skin growths.

Doctor_____

Address_____

City_____ Zone____ State_____

perhaps drop by my home afterward?"

And I know one New York internist who keeps a card file on referring doctors. He notes down any care he gives to them or their families, social encounters, and various other matters. As a result, he can personalize his thank-you notes with additional comments like these:

"I hope your daughter has had no further trouble with her anemia." Or: "Incidentally, I read your state medical journal paper with great interest." Or: "I hope to see you at the next society convention, since I find you're to be a delegate."

Such notes are good business. But they're more than that to the internist I'm talking about. "I sincerely like getting to know my fellow practitioners," he says.

For Treating You

Thanks for professional courtesy. There's no reason to feel embarrassed about accepting professional courtesy, even if you may never get a chance to return it. As one noted surgeon has told me:

"I'm proud to be chosen by another physician. I don't give professional courtesy on a you-scratch-my-back-and-I'll-scratch-yours basis. I consider it a privilege to care for a doctor or his family."

Still, it's a privilege that becomes doubly satisfying when you know that the recipient values your service. And when he tells you so himself instead of letting his wife pick out a basket of fruit for you. A local obstetrician once showed me the following note. "Makes me feel good to get something like this," he commented.

Letter to an OB Man

"Dear Dr. Simpson:

"Jo Ann, whom you delivered for my wife and myself last August, now tips the scale at a handsome sixteen pounds. Mother and child are still doing well, for which we are most grateful. The attached gift is only a token of our appreciation.

"Sincerely,

"Peter Webb, M.D."

The etiquette books agree on a simple formula for such letters: "Thanks for whatever you've done, which has come out in such-and-such a way and has been useful or satisfying to such-and-such a degree." MORE▶

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Ten months ago this woman's physician advised a strict dieting regimen. To accustom her to a limited menu at mealtimes, as well as to inhibit between-meal "nibbling," he prescribed 'Dexedrine' Spansule capsules. During the first few months of reducing, 'Dexedrine' helped inure her to a diet of low-calorie, often "uninteresting" foods. When her physician withdrew 'Dexedrine', *the patient maintained her dieting regimen.* She ate with moderation—without the aid of 'Dexedrine'—because good eating habits had been established. 'Dexedrine' will help your own overweight patients to form new, *permanent* good eating habits.

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Supplied: Capsules, bottles of 36. Each capsule contains penicillin V, 62.5 mg. (100,000 units); salicylamide, 194 mg.; promethazine hydrochloride, 6.25 mg.; phenacetin, 130 mg.; mephentermine sulfate, 3 mg.

antibacterial
analgesic
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You are cordially invited to try PEN·VEE·*Cidin in your practice*

For a generous clinical supply and professional literature, write to Professional Service Dept. A, Wyeth, P.O. Box 8299, Philadelphia 1, Pa.

This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Child Health.

It's a topnotch formula, especially when applied after the full fruits of the gift are clear. Here, for instance, is a note recently received by a Washington, D. C., dermatologist:

"Dear Dr. Knapp:

"You will recall treating my daughter Susan for acne two years ago. I wrote you at the time that she was doing well. Now, I'm happy to say, her complexion has cleared entirely as a result of your therapy, and we're extremely grateful. Susan is off at college. She has joined an excellent sorority, has a part in the Theatre Group play, and is enjoying life in many ways that might not have been possible without your aid. So thanks once again, and best wishes.

"Sincerely,

"John L. Dunn, M.D."

For Presents

Thanks for gifts. When a doctor sends you a gift as an expression of his gratitude for a professional-courtesy service, you naturally want to acknowledge it. In such cases, it's apparently quite all right for your wife to write the note, provided the present was sent to or intended for your home. One typical letter in my collection:

"Dear Dr. Moore:

"Dr. Brown and I are both delighted with the lovely lamp you sent us. It fits in splendidly with the décor of our sunroom, so we're using it there. Please accept our gratitude and best wishes.

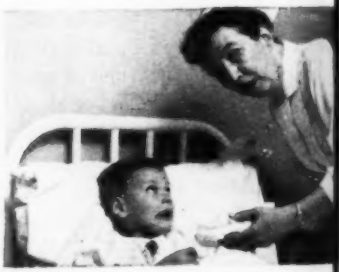
"Clementine Brown"

It seems to me, though, that there's a trend toward more informal, personal, doctor-doctor replies to courtesy gifts. Last December, I got such a note. It was a small Christmas card on which the doctor had written: "Thanks for the handsome planter. It brightens my office considerably."

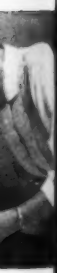
Frankly, I was more grateful for those words in the specialist's own hand than I'd have been for a polite thank-you letter from a wife I've never seen.

To put it another way: It isn't just grateful words that make us proud of our profession and its practitioners. It's the knowledge that a fellow physician recognizes our small services to him —or to medicine in general— and appreciates them enough to tell us so. END

FOR PROMPT, SAFE** CONTROL



OF SPONTANEOUS BLEEDING



"PREMARIN" INTRAVENOUS has been used effectively to control spontaneous bleeding as in epistaxis, post-tonsillectomy and postadenoidectomy hemorrhage, as well as pre- and postoperatively to minimize bleeding after surgery. "PREMARIN" INTRAVENOUS may be used adjunctively with other therapy.

*Bleeding was stopped, in more than 80% of 668 cases reported,[4] with one 20 mg. injection of "PREMARIN" INTRAVENOUS.

**Some 400,000 injections of "PREMARIN" INTRAVENOUS have been made to date without a single report of toxicity or production of thrombi.

HOW "PREMARIN" INTRAVENOUS CONTROLS BLEEDING

Recent studies by Johnson[1,2] reveal that "PREMARIN" INTRAVENOUS controls bleeding through its effect on three important factors in the coagulation mechanism:

BASIC COAGULATION MECHANISM	EFFECT OF "PREMARIN" INTRAVENOUS
PROTHROMBIN in presence of Calcium ions Thromboplastin	Within 15 minutes, prothrombin concentration is increased.
ACCELERATOR GLOBULIN is converted to **THROMBIN** which activates **FIBRINOGEN** to form **FIBRIN** (clot)	Marked increase in accelerator globulin is noted within 15 to 30 minutes. Also known as "factor V" and "proaccelerin," accelerator globulin has "enormous influence on the velocity of thrombin formation..."[3]
anticoagulation factor **ANTITHROMBIN** (inhibits thrombin)	Simultaneous reduction of antithrombin "increases the amount of potential thrombin available and also tends to make it more effective."[1]

"PREMARIN" INTRAVENOUS (conjugated estrogens, equine) is supplied in packages containing one "Secule"® providing 20 mg., and one 5 cc. vial sterile diluent with 0.5% phenol U.S.P.

1. Johnson, J. F.: Proc. Soc. Exper. Biol. & Med. 94:92 (Jan.) 1957. 2. Idem: Paper presented at Symposium on Blood, Wayne State Univ., Detroit, Mich., Jan. 18, 1957. 3. Owren, P. A.: Northwest Med. 56:31 (Jan.) 1957. 4. Published and unpublished case reports.

"PREMARIN" INTRAVENOUS

The Physiologic Hemostat

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5763

[CONTINUED FROM 89] members. Bigger groups have to form committees to make the investment decisions. That way, you lose some of the advantages of a club.

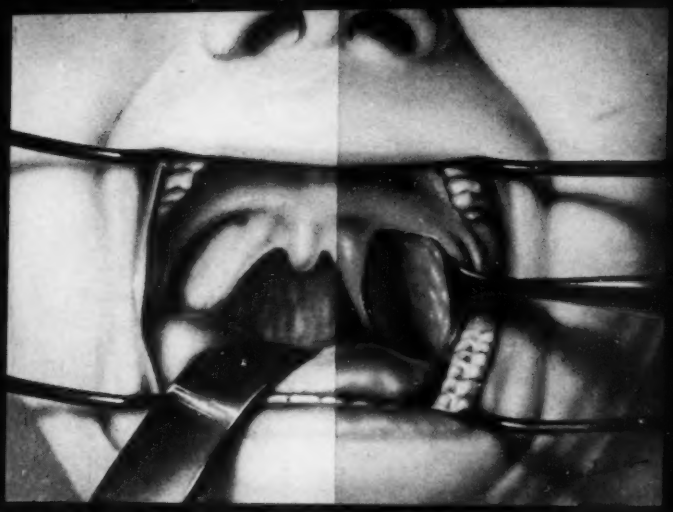
3. *How many meetings?* Most clubs meet monthly to collect payments and discuss investment possibilities. At the first meeting, they draw up operating rules and elect officers. At the second meeting, they often have a stock broker attend. He explains how his firm can help the club get its investment program off the ground.

4. *How much will members invest?* That's entirely up to you. Monthly payments per man vary from $5 to $1,000 in the clubs I know about. You can require the same fixed amount from each man, or you can let him vary his investment from month to month, within limits.

Members' Choice

5. *Who picks the investments?* You do, with the help of your investment broker. He'll supply you with financial information on the companies you're interested in. But decisions are yours.

Most clubs have one or two members study up on a company or industry and report at the next meeting. Then the members



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Chewing ORABIOTIC releases a soothing flow of saliva laden with two locally potent and complementary antibiotics—*neomycin and gramicidin*—plus a topical analgesic, *propesin*, which is more effective than benzocaine.

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for topical treatment or prophylaxis

For the relief of postoperative discomfort and the prevention of secondary hemorrhage following tonsillectomy. Valuable also as a topical adjunct to systemic treatment of bacterial infections of the mouth and throat.

EACH TROCHE CONTAINING: neomycin 3.5 mg., gramicidin 0.25 mg., and propesin 2.0 mg.

IN PACKAGES OF 20. One troche chewed for 10-15 min. q. 4h.

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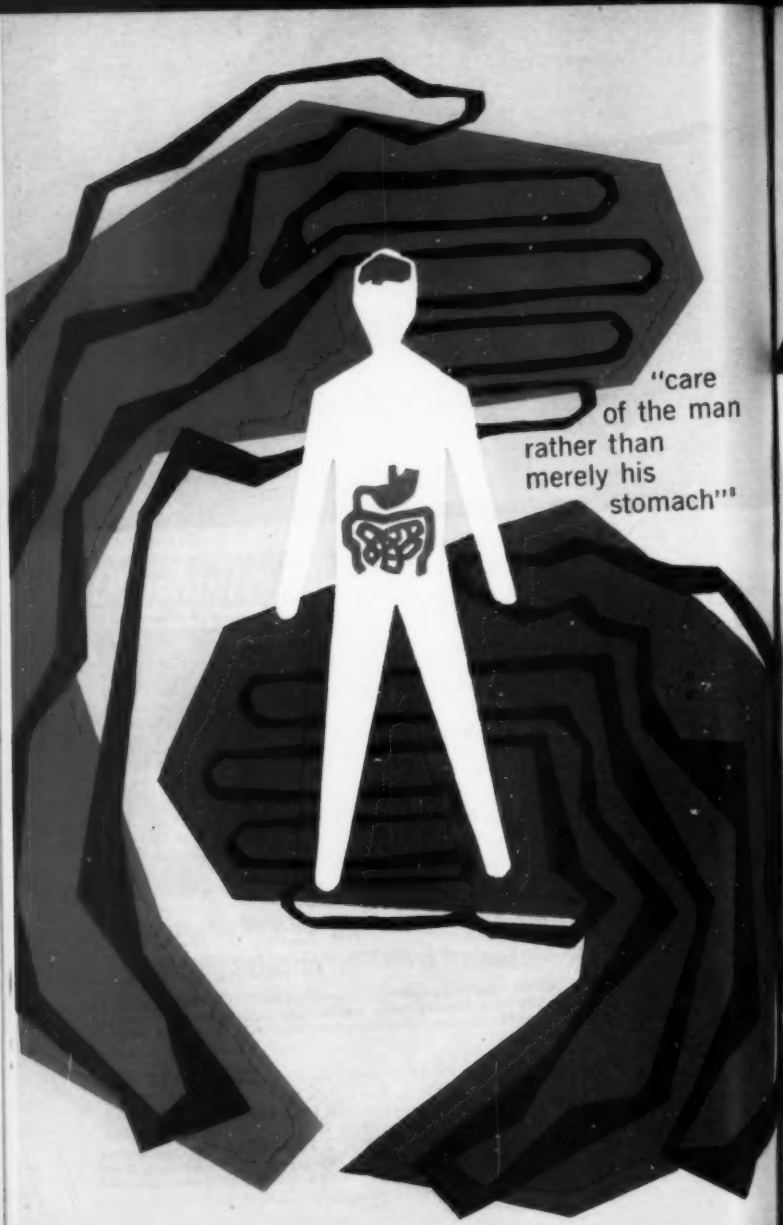
**Granberry, C., and Beatrous, W. P.: The Effect of an Antibiotic Chewing Troche on Post-Tonsillectomy Morbidity, E. E. N. T. Monthly (May) 1957.*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of the man
rather than
merely his
stomach"

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at the central level The tranquilizer Miltown® reduces anxiety and tension.[1, 2, 6, 7]
Unlike the barbiturates, it does not impair mental or physical efficiency.[5, 7]

at the peripheral level The anticholinergic tridihexethyl iodide reduces hypermotility and hypersecretion.
Unlike the belladonna alkaloids, it rarely produces dry mouth or blurred vision.[3, 4]

indications: peptic ulcer, spastic and irritable colon, esophageal spasm, G. I. symptoms of anxiety states.

each "Milpath" tablet contains:

Miltown® (meprobamate WALLACE) ..... 400 mg.
(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

Tridihexethyl iodide ..... 25 mg.
(3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)

dosage: 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

available: bottles of 50 scored tablets.

references: 1. Altschul, A. and Billow, B.: The clinical use of meprobamate (Miltown®). New York J. Med. *57*:2361, July 15, 1957. 2. Atwater, J. S.: The use of anticholinergic agents in peptic ulcer therapy. J. M. A. Georgia *45*:421, Oct. 1956. 3. Borrus, J. C.: Study of effect of Miltown (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate) on psychiatric states. J. A. M. A. *157*: 1596, April 30, 1955. 4. Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer. Am. J. Digest. Dis. *1*:301, July 1956. 5. Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Experimental studies of behavioral effects of meprobamate on normal subjects. Ann. New York Acad. Sc. *67*:701, May 9, 1957. 6. Phillips, R. E.: Use of meprobamate (Miltown®) for the treatment of emotional disorders. Am. Pract. & Digest Treat. *7*:1573, Oct. 1956. 7. Selling, L. S.: A clinical study of Miltown®, a new tranquilizing agent. J. Clin. & Exper. Psychopath. *17*:7, March 1956. 8. Wolf, S. and Wolff, H. G.: Human Gastric Function, Oxford University Press, New York, 1947.

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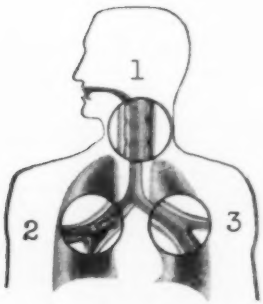
breaks up cough*



*Drawing shows how 3-pronged attack of Pyribenzamine Expectorant with Ephedrine breaks up cough by: (1) reducing histamine-induced congestion and irritation throughout the respiratory tract; (2) liquefying thick and tenacious mucus; (3) relaxing bronchioles. Pyribenzamine Expectorant with Codeine and Ephedrine also available (exempt narcotic). Pyribenzamine® citrate (tripelennamine citrate CIBA). **C I B A** Summit, N. J.

vote their choice. Absent members can vote by proxy, and a majority rules.

Four-Point Program

Many clubs follow this four-point investment program recommended by the N.A.I.C.:

¶ Invest a fixed sum each month, regardless of the current market outlook.

¶ Reinvest all dividends and capital gains.

¶ Invest only in growth companies.

¶ Diversify investments in order to lessen the risk of loss.

6. *Who holds the stock?* The club's broker usually holds the securities, collects dividends for you, and gives you a monthly statement. Most brokers prefer that one or two club members be named to act as agents. The account will then generally be maintained in the agents' names and not in the club's.

7. *What happens if you want out?* That's something to be decided when the club is formed. In the model rules suggested by the N.A.I.C., you can quit at any time on written notice to the club president. The club's portfolio is valued as of the date of the next regular meeting, and you receive your proportionate share of cash or securities. Under the N.A.I.C. model rules, you'd be charged with a 1 per cent penalty plus any commissions incurred to secure cash for you.

Before you sign up with an investment club, there are two alternatives worth considering: the Monthly Investment Plan and the mutual funds.

How They Compare

Like a club, the M.I.P. is a regular savings-investment plan. The investment decisions are yours to make, but you arrange to invest a fixed amount each month through your broker. One disadvantage: You may not be able to diversify your holdings as quickly as you normally could through a club.

If, on the other hand, you invest in a mutual fund, your shares will represent a diversified list of securities and be managed by professionals. A few medical societies have arranged to have individual members pool their savings and buy mutual fund shares in a lump sum. In that way, they can arrange to lower sales commission.

Investment clubs offer no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Bill me through my nearest SPD Dealer, or the SPD Dealer I have listed below.

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(name)
_____
(address)

Surgical Supply Dealer _____ (name)
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such economy. Club purchases are charged the usual brokerage commission. A few brokerage houses have even been known to slap a somewhat higher service charge on investment club accounts.

But investment clubs have one attraction that other methods of investment can't duplicate. One doctor who's tried them all puts it this way: "The club meeting is my only social event of the month that makes money for me instead of costing me money." END

"'You are old, Father William,'
the young man said,
'And your hair has become
very white;
And yet you incessantly stand
on your head—
Do you think at your age,
it is right?'"

ALICE'S ADVENTURES IN WONDERLAND*
DRAWING: JOHN TENNIEL, COURTESY GROSSET & DUNLAP

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to dilate constricted intracranial vessels and increase circulation in older patients.

VASTRAN helps relieve fatigue by increasing intracranial circulation and improving cerebral nutrition, brings a comfortable sense of warmth and well-being. VASTRAN relieves elderly patients' cold hands and feet through warming peripheral vasodilating action of nicotinic acid.

VASTRAN also contains essential B-complex coenzyme factors and ascorbic acid to enhance cellular metabolism.

VASTRAN *is versatile:* Indicated in osteoarthritis, bursitis, myositis, fasciitis, tendinitis, peripheral neuritis, low back disorders and common strains. VASTRAN is also beneficial in intermittent claudication, Raynaud's disease, Buerger's disease, thromboangiitis, chilblains and cold hands and feet.

Each VASTRAN® tablet contains: nicotinic acid, 50 mg.; ascorbic acid, 100 mg.; riboflavin, 5 mg.; thiamine mononitrate, 10 mg.; pyridoxine HCl, 1 mg.; cobalamin (vitamin B_{12} activity), 2 mcg.; calcium pantothenate, 5 mg.

Dosage: VASTRAN 1 tablet q.i.d. before meals.

VASTRAN AMP—more than injectable VASTRAN: In acute or severe conditions, start therapy with injectable VASTRAN AMP solution. Rapid vasodilation is complemented by adenosine-5-monophosphoric acid, as an aid in restoration of normal muscle function through increasing energy stores at the biochemical level. VASTRAN AMP contains in each cc.: nicotinic acid (as sodium salt), 20 mg.; adenosine-5-monophosphoric acid (as sodium salt), 25 mg.; and vitamin B_{12}, 75 mcg.

Note: VASTRAN tablets, for peripheral circulation impairment, are not to be confused with VASTRAN FORTÉ capsules, for hypercholesteremia.

References and literature on request

**For your complimentary first edition portfolio of 8 full-color "Alice" prints from the famous Tenniel plates, 8½" x 11", suitable for framing (value $7.50), write to:*

Add Vastran to the over-all treatment of your aging patients.

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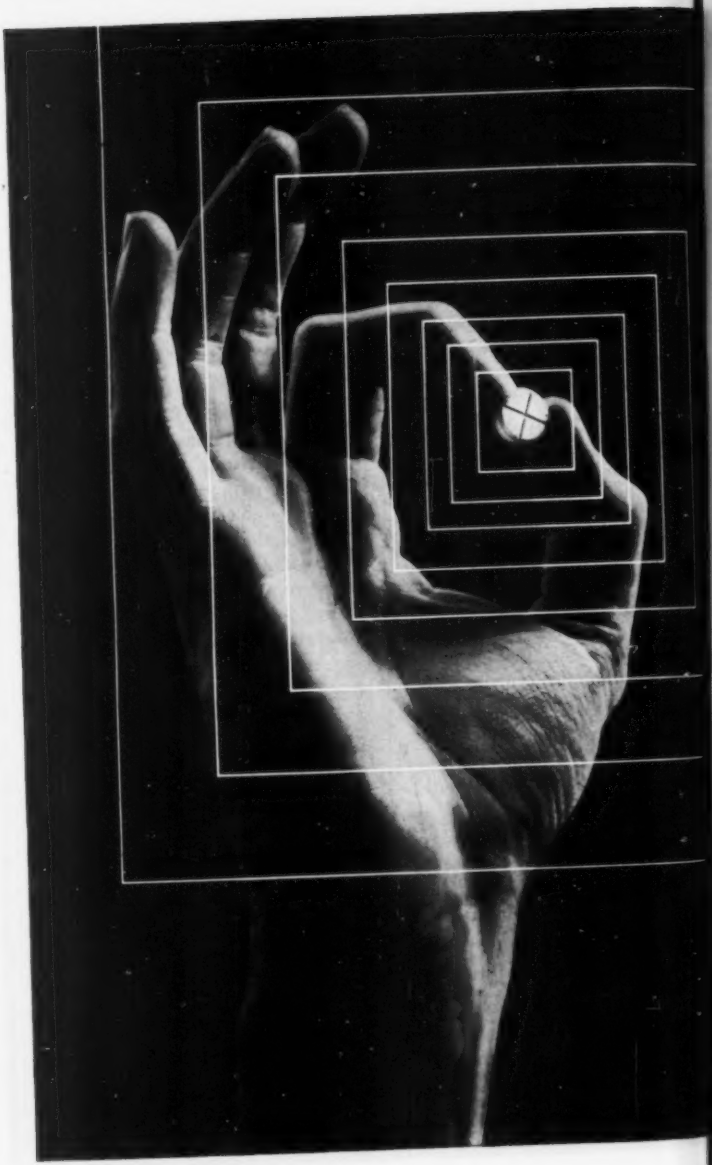

a new era

in sulfa therapy

ONLY ONE TABLET A DAY

KYNEX*

SULFAMETHOXYPYRIDAZINE (3-SULFANILAMIDO-6-METHOXYPYRIDAZINE) LEDERLE

New authoritative studies prove that KYNEX dosage can be reduced even further than that recommended earlier.[1] Now, clinical evidence has established that a single (0.5 Gm.) tablet maintains therapeutic blood levels extending beyond 24 hours. Still more proof that KYNEX stands alone in sulfa performance—

- Lowest Oral Dose In Sulfa History—0.5 Gm. (1 tablet) daily in the usual patient for maintenance of therapeutic blood levels
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- Effective Antibacterial Range—exceptional effectiveness in urinary tract infections
- Convenience—the low dose of 0.5 Gm. (1 tablet) per day offers optimum convenience and acceptance to patients

NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

TABLETS: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

SYRUP: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF. Lederle

[CONTINUED FROM 100] intellectual crowd can view their own body parts with complete detachment.

And here's a last—much neglected—everyday visual aid: your own hands. My favorite orthopedist has a special talent for what you might call hand-sculpture.

"Your hip joint should look like this," he told a recent patient. As he spoke, he held his right fist loosely in his cupped left hand, with the right wrist cocked. "It ought to let you move your thighbone back and forth and from side to side. But it doesn't."

By moving the fist, he showed what he meant. Then he pointed to his wrist and twisted it hard. "You see, you've had a break here that's left the bone bent at the wrong angle. That makes your leg shorter and keeps it from moving freely."

For three-dimensional demon-

"And another thing, Miss McGonigle: When it's time for another patient to come in, you don't holler, 'Next victim!' "

even if your patient is a

gandy dancer†

†railroad man's term for track section hand

...he'll be back on the track with

FLEXILON*

(FLEXIN® + TYLENOL®)

Low back syndromes... sprains... strains rheumatic pains...

FLEXILON gets them back on the job *fast.*

Each tablet contains:
FLEXIN* Zoxazolamine‡ . . . . . 125 mg.
The most effective oral skeletal muscle relaxant
TYLENOL® Acetaminophen . . . . 300 mg.
The preferred analgesic for painful musculoskeletal disorders
supplied: Tablets, enteric coated, orange, bottles of 50.

‡U.S. Patent Pending *Trade-Mark

McNEIL LABORATORIES, INC · PHILADELPHIA 32, PA.

strations, says this orthopedist, there's nothing like the human hand. His patients evidently agree with him.

Commercial Aids

2. You can buy or borrow visual aids or materials. Do you have to explain the same kind of thing over and over again? Normal gestation, cataract surgery, use of a diaphragm, the expected course of measles, for instance? If so, a few dollars spent on special equipment will more than repay you in saved time and better understanding. (The money is tax-deductible, too.)

Take a slide viewer, for example. Dr. Nolan, who teaches pediatrics besides carrying on a lively practice, assembled his slide collection mainly for student use. But one day he happened to have a viewer in the office when a boy with measles was brought in.

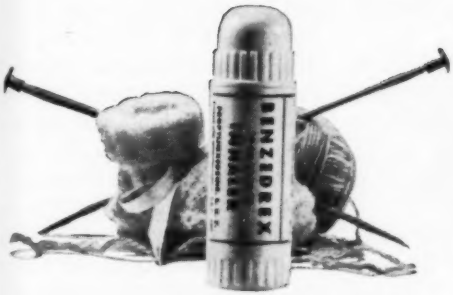
"Let me show you what will happen to Jerry," he said to the boy's mother. "See, here's a slide of a patient at the same stage he's in now. Here are six more, one for each day until he's ready to go back to school. See how the rash changes? And the boy looks less and less ill?"

The mother was enthusiastic —so much so that the word got around. Other parents began asking Dr. Nolan to show them his pictures. So the doctor now keeps his teaching collection in his desk drawer, where it's handy for everyday use. (Incidentally, he himself isn't a cameraman. Every picture in his file was bought at a reasonable price from an excellent series of duplicated transparencies.)

But the teaching aid most doctors use isn't a slide viewer. It's a model, which will explain three-dimensional matters with a clarity that words just can't match. Plaster models of the female pelvis, the eye, the inner ear, the heart, etc., make a lot of sense to patients. They're relatively inexpensive; and you can get them from various visual-education-equipment dealers.

Do-It-Yourself Aids

3. You can build up your own homemade library of visual aids. When Dr. Peter Adams started his obstetrical practice, he made a simple flip chart—a photo album in which illustrative material was mounted, one item to the page. He used it to illustrate the normal course of pregnancy. The



when **nasal stuffiness** troubles the pregnant patient

Maybe it's an ordinary head cold. Maybe it's a reaction to one of today's valuable new drugs (an antihypertensive, perhaps). Maybe it's due to something else.

No matter. Recommend a 'Benzedrex' Inhaler. Why? Because nose drops and sprays so frequently produce nausea during pregnancy.

The Inhaler, on the other hand, is easily tolerated by even the most squeamish woman. It provides rapid and prolonged vasoconstriction —*without* excitation or wakefulness.

ideal for use between office treatments

Benzedrex* Inhaler

Smith Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

book soon got too bulky to handle. So he divided it into several volumes, one for each month of pregnancy, beginning with the second.

At first he used the books to illustrate personal explanations. As he grew busier, though, he got a bright idea:

Taped Talks

Why not put his explanations on tape, indicate the place to turn the pages with a special sound, and let the patients run through the flip charts by themselves?

If you walk into Dr. Adams' office today, you'll probably find at least one patient listening to the recorder with an album in her lap. "This is what the baby looks like three months after conception," Dr. Adams' voice may be saying. "The womb is now about as big as a grapefruit. See the umbilical cord, which carries blood to and from the baby to the placenta? It's through the placenta that you nourish him."

There's a click-clack noise from the recorder. The patient turns the page, and the doctor's voice carries on:

"Now this one shows how your ovary looks at three months. The bulge labeled #1 gives out hormones that control your uterus and otherwise help your body carry on with the pregnancy. The bands of tissue that hold the ovary in place, labeled #2 on the picture, are loose and pliable. That's why the ovary can flop around—and can sometimes give you a sharp twinge of pain when you roll over at night."

Dr. Adams' taped talks bring the average patient in early for each appointment. They also head off the bulk of routine questions. And they make the doctor's name a household word in the baby-heavy suburbs. With earphones for use when the office is crowded, the patient can listen and look in comparative privacy. But she can seldom resist telling her friends about the talks. Which is all to the good.

The Personal Touch

Such aids can only supplement face-to-face explanations, of course. There's no substitute for the doctor's personal attention. But the more you can make the patient *see* what you're talking about, the better he'll understand his job as a patient and yours as his physician. END

the path to

effective ulcer therapy

with few side effects

Effects of anticholinergic drugs on peptic ulcer[1]

	Atropine	Anticholinergic A	Anticholinergic B	PATHILON
Daily Dose	1.6 mg.	400 mg.	120 mg.	200 mg.
No. patients and length of follow-up	37 11 mo.	27 13 mo.	16 9 mo.	21 11 mo.
Results:				
Good to excellent	51%	74%	56%	76%
Fair to poor	49%	26%	44%	24%
Recurrences:				
None	16%	22%	13%	19%
Few	46%	48%	50%	57%
Same	38%	38%	38%	24%
Complications:				
Hemorrhage	5%	7%	19%	9.5%
Perforation	0%	4%	0%	0%
Obstruction	0%	4%	0%	0%
Surgery needed	3%	4%	6%	0%
Side effects:				
Oral	38%	78%	25%	14%
Visual	11%	48%	6%	0%
Sphincter	11%	15%	0%	0%

Available in three forms: tablets of 25 mg., plain (Pink) or with phenobarbital, 15 mg. (Blue), and parenteral, 50 mg./cc.—1 cc. ampuls.

Dosage: 1 or 2 tablets before each meal and at bedtime. Parenterally, 10 to 20 mg. every 6 hours.

Also available: PATHIBAMATE** Meprobamate with PATHILON LEDERLE, for gastrointestinal disorders and their "emotional overlay."

1. After Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer, Am. J. Digest. Dis. 1:301 (July) 1956.

*Reg. U. S. Pat. Off. **Trademark

in anticholinergic therapy... weigh the benefits against the side effects

PATHILON*

Tridihexethyl Iodide LEDERLE

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK


AZOTREX is the only urinary anti-infective agent combining:
(1) the broad-spectrum antibiotic efficiency of TETREX—the original tetracycline phosphate complex which provides faster and higher blood levels;
(2) the chemotherapeutic effectiveness of sulfamethizole—outstanding for solubility, absorption and safety;
(3) the pain-relieving action of phenylazo-diamino-pyridine HCl—long recognized as a urinary analgesic.
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through comprehensive
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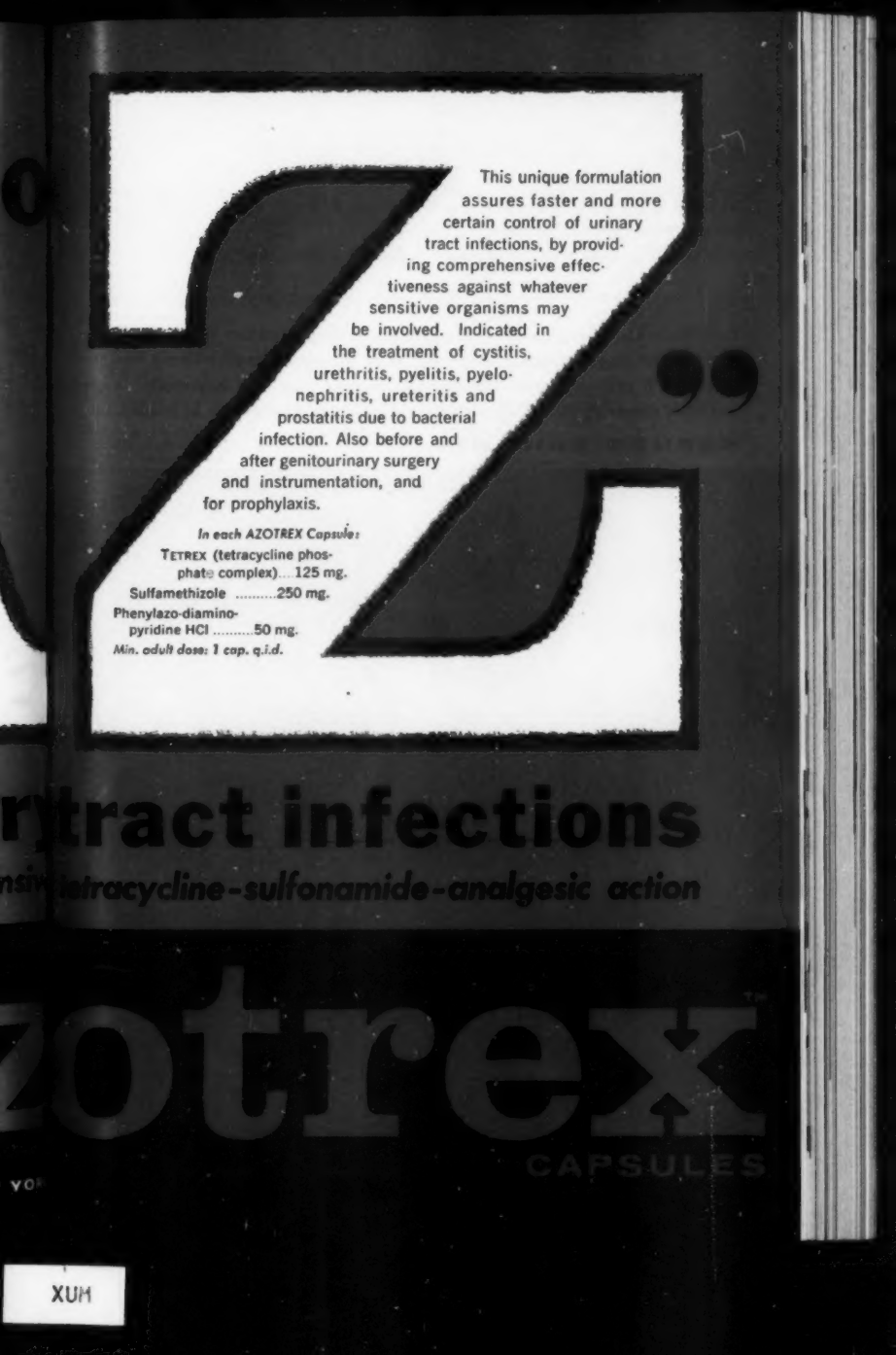
This unique formulation assures faster and more certain control of urinary tract infections, by providing comprehensive effectiveness against whatever sensitive organisms may be involved. Indicated in the treatment of cystitis, urethritis, pyelitis, pyelonephritis, ureteritis and prostatitis due to bacterial infection. Also before and after genitourinary surgery and instrumentation, and for prophylaxis.
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Sulfamethizole .....250 mg.
Phenylazo-diamino-pyridine HCl .....50 mg.
Min. adult dose: 1 cap. q.i.d.
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tetracycline-sulfonamide-analgesic action
zotrex
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Memo

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Who's eligible to get MEDICAL ECONOMICS *without charge?* Physicians in active practice. All others must pay the regular subscription price (now $10 a year).*

What must eligible physicians do to get it? Request it in writing.

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How can you publish a magazine like MEDICAL ECONOMICS *without charging everyone for it?* By gaining the readership of almost every prescribing physician, thus attracting medical advertisers who seek widest impact for ads.

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We do require proof of reading intent. That's the purpose of our subscription form. It's your free ticket to future issues—good only if used. —LANSING CHAPMAN

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Medical Economics

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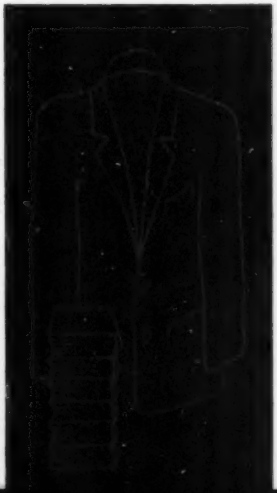

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(oxanamide)

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QUIACTIN—in the recommended dose—one 400 mg. tablet q.i.d., provides greater tranquility with less drowsiness and more prolonged activity.[1] QUIACTIN is remarkably nontoxic, noncumulative and has no withdrawal symptoms.[1-3]

Structurally, QUIACTIN is a completely new tranquilizer... therapeutically, it's different... stops before it goes farther than patient comfort or safety allows. QUIACTIN does not push the patient beyond tranquility into lassitude, dullness, depression.

1. Proctor, R. C.: Dis. Nerv. Sys. 18:223 1957. 2. Feuss, C. D., and Gragg, L., Jr.: Dis. Nerv. Sys. 18:29, 1957. 3. Coats, E. A., and Gray, R. W.: Dis. Nerv. Sys. 18:191, 1957.

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Medical Economics

NEWS BRIEFS

100,000 ILLEGAL ABORTIONS EVERY YEAR are being done by M.D.s, if the women interviewed by the Institute for Sex Research are to be believed. This is the group made famous by Dr. Alfred C. Kinsey. Its new report will be out in May.

RECESSION? It's more an excuse than a real reason for not paying doctors, medical collection agencies report. Details in next issue.

PRIVATE EYE has been hired by the Los Angeles County Medical Association to check up on its own members. "We are employing a private investigator," explains Dr. Donald Cass, "in hopes of bringing to a close the activities of some unethical physicians among our members."

DOCTORS' DONATIONS to medical schools may be falling off, but corporate gifts are increasing. The National Fund for Medical Education now collects more than $2,000,000 annually.